January, 1955

Medical Economics



Fee Complaint

(a case history)

In this issue:

The House of Menninger

Health Bills Caught in Political Wringer

How to Handle Federal Withholding Taxes

Rx INFORMATION

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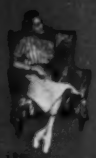
SUPPLIED: In bottles of 70 and 350 capsules, in 30 cc. bottles with calibrated dropper. One bottle of capsules or 2 bottles of oral drops usually suffice for a course of therapy.

References: (1) Greenblatt, R. B., and Barfield, W. E.: Am. J. Obst. & Gynec. 70:1077, 1955. (2) Greenblatt, R. B.: Southern M. J. 48:1322, 1955. (3) Greenblatt, R. B., Dow, A. and Barfield, W. E.: Am. J. Obst. & Gynec. 70:1, 1955. (4) Greenblatt, R. B.: Obst. & Gynec. 5:1, 1955. (5) Greenblatt, R. B.: Am. J. Obst. & Gynec. 70:1, 1955. (6) Greenblatt, R. B.: Obst. & Gynec. 5:1, 1955. (7) Greenblatt, R. B.: Am. J. Obst. & Gynec. 70:1, 1955. (8) Greenblatt, R. B.: Obst. & Gynec. 5:1, 1955. (9) Greenblatt, R. B.: Am. J. Obst. & Gynec. 70:1, 1955. (10) Greenblatt, R. B.: Obst. & Gynec. 5:1, 1955.

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JANUARY 1955

Medical Economics

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This correspondence not only raises a number of interesting questions about how to justify nonsurgical fees; it also sheds valuable light on the underlying problem

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Panorama

Society to poll doctors on all controversial issues • Number of foreign M.D.s on hospital staffs increases • The parking problem and how not to solve it • New three-way insurance package deal

False Alarm Calls

Nearly half the calls handled by the average medical society emergency call service are probably for non-emergency cases—at least according to the findings of one recent study.

The Medical Bureau of the Providence Medical Association has just completed a follow-up review of 200 emergency calls received by the bureau during a two-month period. And only 103 of these were true emergencies, according to the doctors who answered the calls. Some examples of cases that needlessly yanked the physician out of office or bed:

¶ "Chorus girl . . . apparently had a disagreement with one of her friends and she became hysterical."

¶ "Patient had been coughing for two to three weeks."

¶ "Allergic rash."

¶ "Mother very concerned about grown son who had fallen out of bed some time prior to call."

¶ "A case of mild chronic alcoholism."

¶ "Patient had a fall . . . *four* days previously. No visible or palpable signs of injury."

Eighty-seven of the 200 calls came between 6 P.M. and midnight, thirty-seven between midnight and dawn, according to the report. Doctors were paid in two-thirds of the cases, but many of them said they would have preferred their sleep or leisure to fees for night calls that weren't urgent. All agreed on the need for stepping up public education, to emphasize the universal necessity for a family doctor who is always on tap.

Fee Splits Set Back

The American College of Surgeons' all-out campaign against fee splitting* has taken two long strides forward:

1. In Iowa, where the state medical association not long ago sought to liberalize the ethical injunction against fee splitting, the A.C.S. lost

*For a full account of the campaign, see "A.C.S. Closes In on Fee Splitters," MEDICAL ECONOMICS, September, 1954.

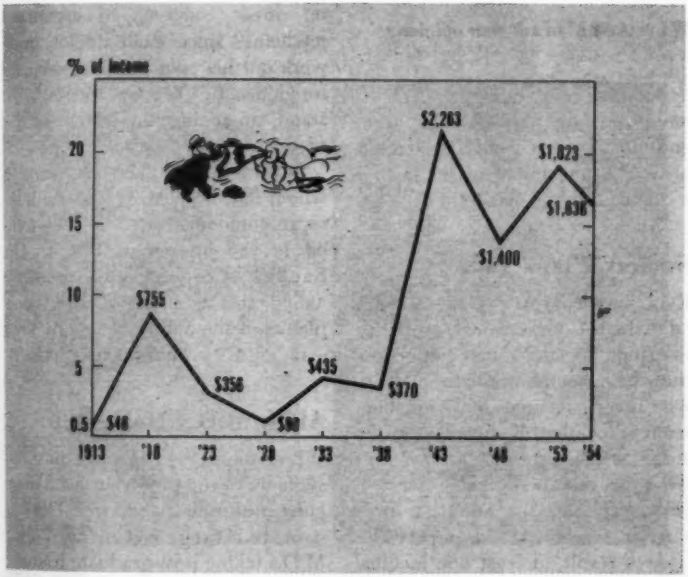
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no time in taking matters into its own hands. In a letter to its 215 fellows in the state, it offered a flat choice: They would consent to submit their books for a yearly audit, or they would resign from the college. At last report, 190 answers had already been received—without a single resignation.

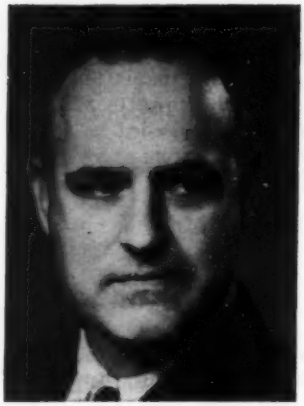
2. In Chicago, the 500 physicians affiliated with gigantic Michael Reese Hospital needed no special prodding to institute a precautionary measure of their own. By unani-

Income Taxes and How They've Grown

All figures used apply to a childless couple with a $10,000 annual income. Deductions amount to 5% for the years through 1943, and to a standard 10% thereafter. Amounts have been rounded off to the nearest dollar.



The above graph is based on a tax study conducted by Professors Alfred P. Koch and Carl L. Moore of Lehigh University, and published in a recent issue of Taxes, the Tax Magazine.



DR. CHARLES S. HIGLEY

Wants A.M.A. to ask *your* opinion

mous vote, they decided that from now on they too would open their books for an annual inspection by a certified public accountant.

Society Plans Poll

Ever since A.M.A. opposition helped defeat Congressional proposals to extend Social Security to doctors, there have been protests from M.D.s who favor coverage. Many of them seem to feel that the A.M.A. took its stand without trying to find out what its members *really* wanted. [For example, see MEDICAL ECONOMICS, October, 1954, page 46.]

As a result, at least one medical society has promised that its policy decisions in future will be based on full knowledge of members' views. Dr. George L. Sackett, president of the Academy of Medicine of Cleveland (Ohio), has announced in the academy's bulletin that members "will be canvassed by questionnaire on important issues" during the year 1955.

Officers of the academy decided there was a need for such polls after publication in the bulletin of one physician's letter touched off a spirited debate among Cleveland M.D.s. Protesting the A.M.A.'s "vigorous lobbying" against Social Security, Dr. Charles S. Higley had argued that the matter of coverage is "of no direct concern" to organized medicine, since each doctor must work out his own financial security for himself. "Yet by the A.M.A. stand, practicing physicians are denied any choice," he said.

Several of his colleagues—some of whom felt the A.M.A. *had* properly represented majority opinion—joined in the argument. Result: Dr. Sackett's recent announcement, aimed at preventing further complaints of the nature of Dr. Higley's—among Cleveland doctors, at least.

Alien M.D.s Help Out

Who is filling the gap left in hospital staffs by young physicians who have gone into military service? The answer, to a large extent: foreign M.D.s taking post-graduate training in the U.S. During the 1953-1954 school year, for instance, nearly

6,000 foreign doctor held house staff posts, as against barely 2,000 only three years earlier.

The alien medical men are steered by the State Department's educational exchange program to 800 hospitals, where they now make up 22 per cent of total house staffs. They've cut vacancies in such institutions down to 20 per cent for residents and 30 per cent for internes.

Thickest concentration of the foreign doctors is in TB and general hospitals, according to a recent survey. Only a few are currently attached to major teaching hospitals. And state laws serve to clump two-thirds of the visitors into five states —New York, Ohio, New Jersey, Illinois, and Massachusetts.

Service-Connected?

How far is the Veterans Administration prepared to go in its liberal interpretation of what constitutes a service-connected case? No one seems to know exactly. But consider the story of Tamara Adel Rees:

When ex-paratrooper Rees (whose name used to be Robert) returned from Holland recently, after a Christine Jorgensen-type operation, one of the first things she



ROBERT REES



TAMARA REES

This sex-switch (not exactly in line of duty) led to free V.A. care

did was to apply for a few days of "psychiatric observation" at a Brooklyn V.A. hospital. Got in, too—as a service-connected case.

What's more, Miss Reese got a free private room and bath. The reason, according to an attending physician: "Separate bathroom facilities seemed a necessity, somehow."

Specialties Preferred

As freshmen, the majority of medical students say they want to go into general practice. Yet, as matters now stand, only a handful actually end up as G.P.s; sometime during their training, most of the men switch their allegiance to a specialty.

Such was the finding of a p conducted recently by the Ma chusetts Academy of General Pr tice. It queried a sampling of dents from all the state's medi schools (as well as a number of ternes and residents), and came with the following arresting figur

Of the first-year students, a wh ping 92 per cent planned to go i general practice. This figure dr ped to 74 per cent for second-y men; to 56 per cent for juniors; to 41 per cent for seniors. Amo the internes and residents, the treat became a rout: All but 19 cent were going in for a specialty

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Massachusetts academy—to whom these figures are naturally a cause for concern—found five reasons uppermost in students' minds:

1. "Present-day medicine has become so complicated that it would be impossible to practice it, unless one specialized in a limited field."

2. There's a widespread impression that specialists will replace family physicians everywhere before long.

3. "Specialists have better hours, fewer night calls, and a higher income."

4. "You have to be a specialty board member to be on the staff of most good hospitals."

5. The medical schools offer too little training in general practice.

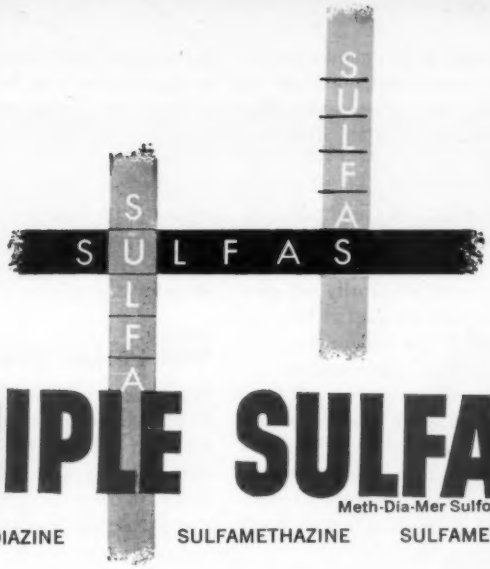
Income Tax Tips

The new (April 15) date for filing Federal income tax returns gives you some extra time to familiarize yourself with some of the liberal features of the present tax law. Here are a couple of tax-saving possibilities you may have overlooked:

¶ In figuring your deduction, if any, for medical expenses, you can include the fee charged your youngster for a college health plan. One qualification, however: Such a fee must be billed separately from tuition and board and room fees; or, at least, you must obtain from the school an exact account of its charges for the plan.

¶ You may be able to get more

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rapid recovery of the money you've spent for equipment, because of liberalized depreciation rules. The 1954 tax law permits more latitude in determining the useful life of depreciable property; and, naturally, the shorter the life assigned, the larger the annual depreciation allowance.

You may not arbitrarily set your own estimate of useful life, of course. But if you believe that, because of special circumstances, some piece of equipment will have a shorter useful life than the standard period assigned to it, you may now ask the tax men for a concession; and if the Treasury Department feels your claim is just, you'll get a signed agreement fixing a faster depreciation rate for the item.

It seems likely, too, that the Treasury will soon revise its estimates of useful life, to make them more realistic. Look for a 1955 revision of the Treasury's Bulletin "F"—the book that lists the useful life assigned for tax purposes to various items of depreciable property.

Will Permit Oral Rxs

Pharmacists will shortly be allowed to fill your telephoned prescriptions for some non-addiction-forming narcotics compounds (such as certain types of quarter-grain codeine items). A bill legalizing such oral



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1. Blanchard, K. and Ford, R. A., Effective Antitussive Agent in the Treatment of Cough in Childhood, Journal-Lancet, 74:48, Nov., 1954.* 2. Cass, L. J. and Frederik, W., Comparative Clinical Effectiveness of Cough Medication, Amer. Pract. and Dig. of Treat., Vol. 2, p. 844, October, 1951.*

*Reprints available upon request.

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prescribing—the Martin amendment to the Harrison Narcotic Act—has already been signed by the President. Now, just one hitch remains: In most states, any law dealing with the dispensing of narcotics must also be approved by the state legislature. It's expected, however, that most such bodies will soon ratify the bill.

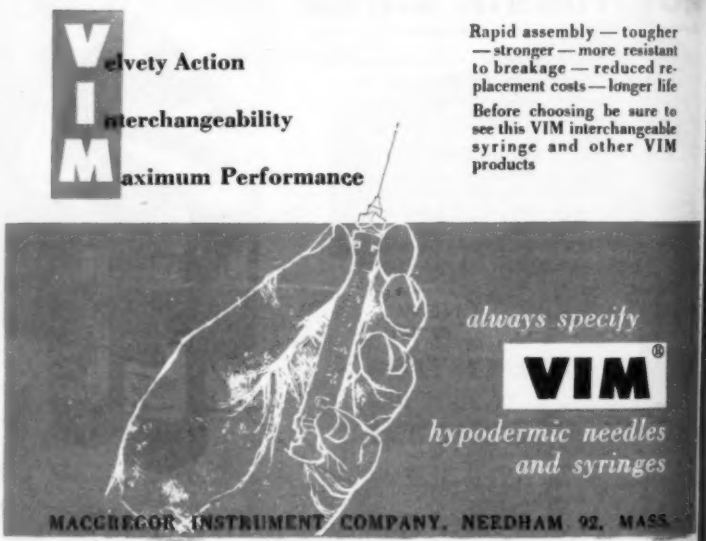
More Parking Woes

Parking, always a nagging problem for city doctors, can sometimes become a major headache. Consider what happened to New York City's 19,000 physicians recently, when the traffic department made sweeping new regulations designed to ease the situation for the city's 600,00 drivers:

The new laws didn't grant phys cians additional parking privileges. Far from it. Instead, the doctor were restricted to one-hour parkin at offices and at patients' homes, an to three hours at hospitals.

The medical men said they ha no quarrel with the one-hour limi on house-call parking—particularly in view of the traffic department's assurance that the law would be lib erally interpreted. But they did ob ject to the restrictions on office and hospital parking. These, they insist ed, were thoroughly "unrealistic."

Accordingly, Dr. Peter M. Mur ray, president of the Medical Soci



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ety of the County of New York, announced that his society would fight to have the regulations amended. His aim: three-hour office and five-hour hospital parking. His two-pronged argument in favor of the revision:

1. While at the office, doctors must have their cars handy at all times, to take care of emergency calls. (And most physicians, Dr. Murray pointed out, spend more than an hour at a time in the office.)

2. Hospital rounds generally take the doctor more than three hours, he maintained. And he warned that if the new regulations forced a curtailment of the doctor's hospital time, the public would be bound to suffer.

At last report, it wasn't clear who would carry the day—the traffic department or the city's outraged medical men.

Trends in Saving

Where are you putting the dollars you're stashing away for a rainy day? Are your savings habits like those of most Americans?

Some significant shifts in investment trends are indicated in the latest figures released by the U.S. Securities and Exchange Commission. For example, take the rising appeal of the savings and loan associations: While bank savings slipped from $6.5 billion in 1953 to $5

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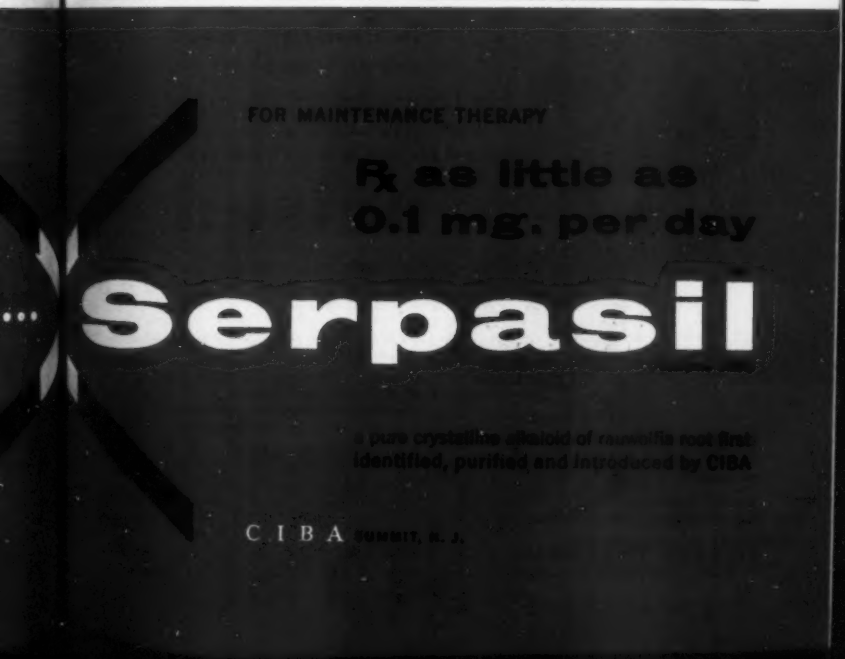
billion in 1954, savings and loan shares rose from $3.5 billion to $4 billion. Thus, the public now hands the fourth largest slice of its total savings pie to the associations.

Largest share ($8.1 billion) still goes to insurance and pensions. But these too—like bank savings and corporate securities—seem to be slipping in popularity. The figures show that Americans are investing more and more of their money in U.S. savings bonds and tax-free state and municipal bonds, as well as in the savings and loan companies.

In addition, they're paying off old debts at a record rate. Says U.S. News & World Report, commenting on the S.E.C. findings: "Payments on old debts . . . exceeded all new installment credit extended in six of the first eight months of 1954 . . . People, generally, are hesitating to take on new debts, and are setting aside dollars in relatively large amounts."

New Insurance Plan

In the past, life insurance companies have concentrated on selling insurance alone. But one of their number is now branching out: The Farm Bureau Insurance Companies (of Columbus, Ohio) recently began selling a three-way package plan that includes mutual investment fund certificates and retirement in-

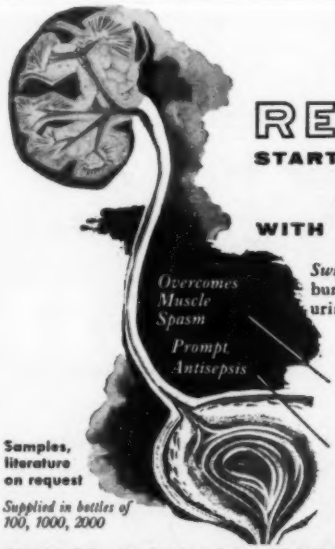


come as well as life insurance. The company's stated objective: to provide policyholders with a well-balanced financial program that will bring *all-around* security. Here, briefly, is how the plan works:

The investor agrees to buy shares in the Mutual Income Foundation (a recently acquired Farm Bureau affiliate)—for example, through a ten-year monthly payment plan. He can do so with an initial investment of, say, $500 and monthly payments thereafter of $100. Too, he's eligible for a Farm Bureau term insurance policy (costing about 75 cents a month per $1,000 of insurance).

The advantage of the tie-in, according to company officials, is that the insurance policy is so geared that it will always provide enough money to complete the policyholder's investment program in case of his death. Another feature: As the investor's stake in the mutual fund rises, the amount of insurance in force automatically decreases.

The investor can, of course, pull out of M.I.F. at any time. But it's to his advantage to hold (and collect dividends on) his shares until he's 60 or 65. That's when the retirement part of the plan becomes operative: The company begins to pay back all accumulated funds, holding out only a small amount to pay for a monthly life-income annuity that begins at age 75. END



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KUTAPRESSIN is a highly selective vasoconstricting principle acting on abnormally dilated terminal arterioles and capillaries without raising systemic blood pressure. Free from side-effects, it has been used with encouraging results in such diverse applications as herpes zoster, drug dermatoses, eczemas, third-degree burns and graft preparations, and in reducing postoperative bleeding following tonsillectomies, adenoidectomies, etc. There are no known contraindications.

DOSAGE: Average, 2 cc. intramuscularly or subcutaneously, daily or thrice weekly until improvement is obtained. In severe cases, 5 cc. may be administered initially, and subsequently reduced.

SUPPLIED: As aqueous solution in 10- and 20-cc. multiple-dose vials.

1. Pensky, N., and Goldberg, N.: New York State J. Med. 53:2238, 1953. 2. Nierman, M. M.: J. Indiana M. A. 45:497, 1952. 3. Knox, J. M.: Preliminary Report, U. S. Navy Medical News Letter, vol. 20, Nov. 14, 1952. 4. Lubowe, I. L.: Clin. Med. 59:354, 1952. 5. Poole, W. L.: To be published. 6. Kalb, C.: To be published. 7. Marshall, W.: M. Times 79:222, 1951.

[*]Case report.



Two months later: "the skin was dry . . . the whole face markedly improved"[*]

Professional Literature Available

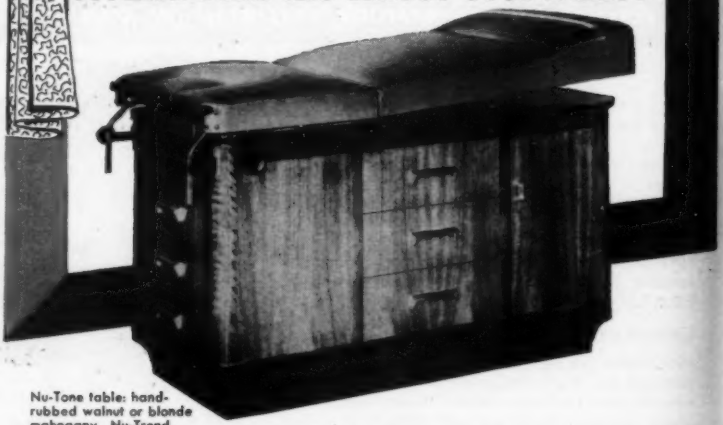
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with lactose in a water-miscible base, buffered with lactic acid to pH 4.5.

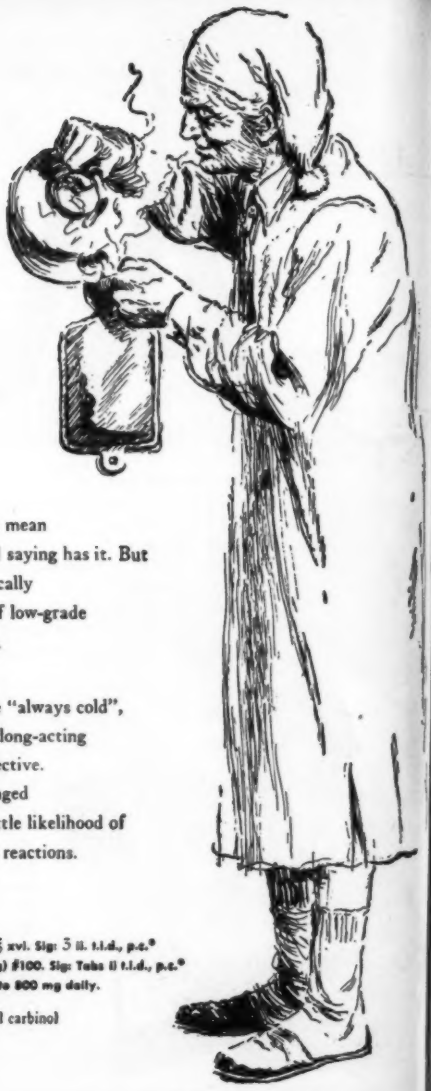
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*Hensel, H. A. *Postgrad. Med.* 8:293, 1950*

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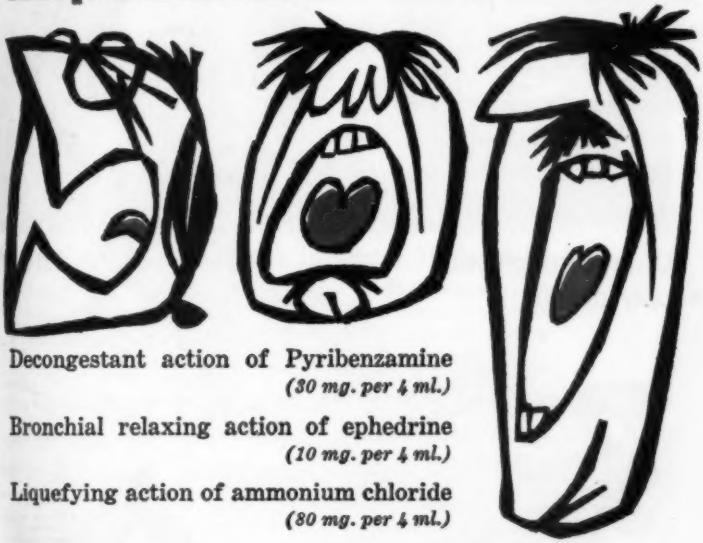
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Pyridoxine Hydrochloride (B_6)	0.5 mg.
Ca Pantothenate**	5.0 mg.
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Inositol**	50.0 mg.
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Vitamin E (tocopheryl acetates)**	10.0 Units
Rutin**	25.0 mg.
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Iodine (KI)	0.5 mg. (500% MDR)
Calcium ($CaHPO_4$)	145.0 mg. (19% MDR)
Phosphorus ($CaHPO_4$)	110.0 mg. (14.6% MDR)
Boron ($Na_2B_4O_7.10H_2O$)**	0.1 mg.
Copper (CuO)**	1.0 mg.
Fluorine (CaF_2)**	0.1 mg.
Manganese (MnO_2)**	1.0 mg.
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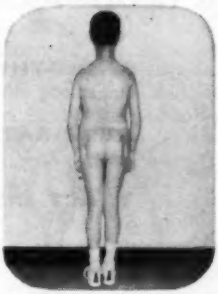
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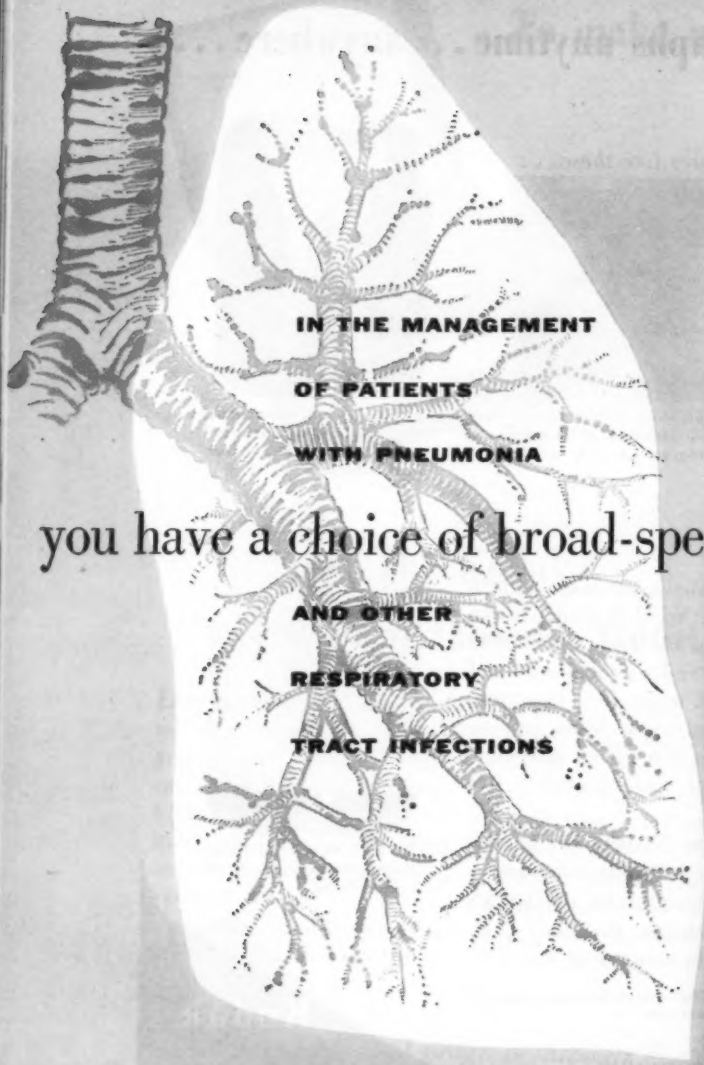
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O'Regan, C., and Schwarzer, S.: J. Pediat. 44:172 (Feb.) 1954.

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Waddington, W. S.; Bergy, G. G.; Nielsen, R. L., and Kirby, W. M. M.: Am. J. M. Sc. 228:164 (Aug.) 1954.

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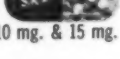


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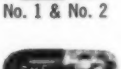


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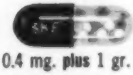


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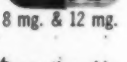


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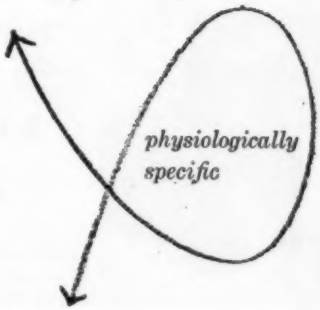
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1. Sivertsen, E.: Hvalradets Skrifter, Scientific Results of Marine Research, No. 26, Oslo, 1941.
2. Gunther, M.: Brit. J. Nutrition *6* (No. 2) :215, 1952.

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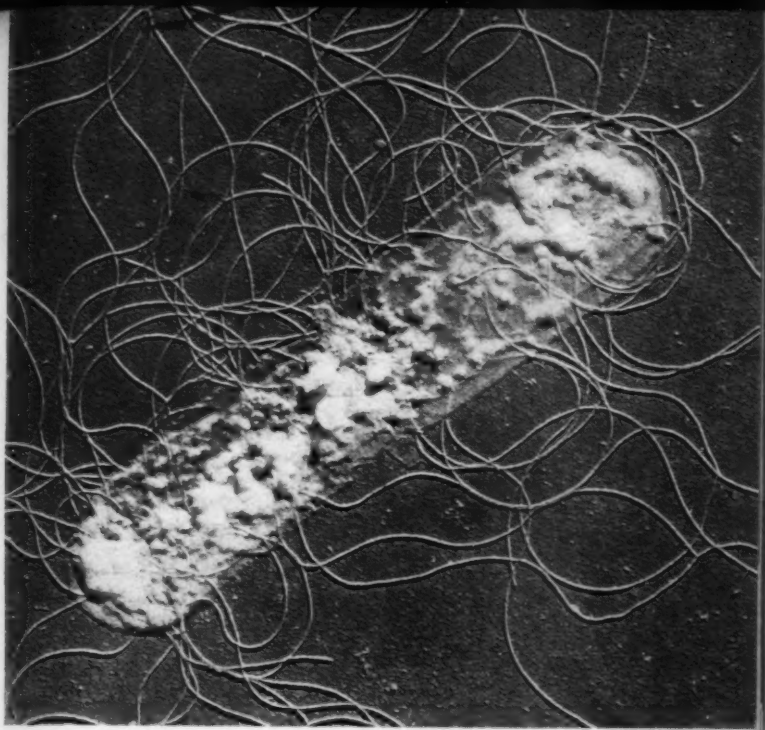
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1. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.
2. White, C. J., A New Anesthetic for Certain Diseases of the Skin, J. Lancet, 74:98, March, 1954.
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4. Schwartz, F. R., Tronothane in Common Pruritic Syndromes, Postgrad. Med., 16:19, July, 1954.

AFTER 16 YEARS... THE SAME CONCLUSION

"Approximately 39 to 47 per cent of resistant cases are reinfections from the sexual partner."[1]

In 1938 Karnaky[1] published a study of 150 women with recurring Trichomonas vaginalis infestations. No less than 38 of the husbands were also infected with the organisms which were recovered from the urethra, the prostate, or under the prepuce. A review of the literature at that time led Karnaky to estimate that "approximately 39 to 47 per cent of resistant cases are reinfections from the sexual partner."

In the June 26, 1954 issue of *The Journal of the American Medical Association,* Karnaky discusses the incidence of reinfection with Trichomonas vaginalis, and after evaluation of over a 1,000 cases, reiterates: "The real focus has been the male generative organ."[2]

In a recent study by Whittington,[3] the incidence of male infestation was 27 per cent. Trichomonal vaginitis occurs in "30 to 40 per cent of unselected patients," according to Upton.[4] He, too, finds, "Reinfection is annoyingly frequent." Donald,[5] working in a special clinic for patients with vaginal discharges, reports that the largest group of those attending the clinic are patients with trichomonal vaginitis, and that the relapse ratio is over 22 per cent. The majority of infections were due to sexual intercourse.

As one of the therapeutic measures in the treatment of Trichomonas vaginalis infections, Karnaky[1,2] recommends the use of a protective covering for the male during coitus, and suggests that the prophylactic use of a condom be maintained for at least four months. Bernstine and Rakoff[6] also advise the use of a condom "until it is certain the infestation has been cleared up entirely... If both members harbor the organism, similar protection should also be employed for at least three months after both have been apparently cured."

Occasionally, patients will manifest a reluctance to use the condom because of inconvenience, inhibition, or alleged dulling of sensation. These objections are readily overcome following the recommendation and initial trial of pre-moistened, convenient XXXX FOUREX® skins. As these are prepared from the cecum of the lamb, they do not exert any retarding effect on sensory nerve endings. In those cases where cost is a paramount factor, the use of RAMSES,® a transparent, very thin rubber condom, or SHEIK,® a popular-priced brand, will prove eminently satisfactory.

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references:

1. Karnaky, K. J.: Urol. & Cutan. Rev. 42:812, Nov., 1938.
2. Idem: J.A.M.A. 156:876, June 26, 1954.
3. Whittington, M. J.: J. Obst. & Gynaec. Brit. Emp. 58:614, Aug., 1951.
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6. Bernstine, J. B., and Rakoff, A. E.: Vaginal Infection, Infestations, and Discharges, New York, The Blakiston Company, Inc., 1953, pp. 256 ff.

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So Easy, too

No bothersome daytime medication. Just two 2 mg. tablets at bedtime. For maintenance, one tablet h.s. usually suffices.

1. Allen, E. V.; Barker, N. W.; Hines, E. A., Jr.; Kvale, W. F.; Shick, R. M.; Gifford, R. W., Jr., and Estes, J. E., Jr.: Proc. Staff Meet., Mayo Clin. *29*:459 (Aug. 25) 1954.
2. Livesay, W. R.; Moyer, J. H., and Miller, S. I.: J.A.M.A. *155*:1027 (July 17) 1954.

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

THIS ends the confusion about hematinics



ROETINIC*
(it's new)

Only one-a-day hematinic which meets exact U.S.P. requirements for Intrinsic Factor-B_{12} as defined by the Anti-Anemia Preparations Advisory Board... and is so labeled.

ROETINIC*
(it's new)

The most complete oral hematinic: contains therapeutic quantities of *all* established hemapoietic factors, including the "four extra essentials."

ROETINIC*
(it's new)

EACH CAPSULE CONTAINS:

Intrinsic Factor—Vitamin B_{12} Concentrate	1 U.S.P. Oral Unit
Folic Acid	2 mg.
Ferrous Sulfate, Exsiccated	400 mg.
Ascorbic Acid	100 mg.
Molybdenum	1.5 mg.
Cobalt	0.5 mg.
Copper	0.5 mg.
Manganese	0.5 mg.
Zinc	0.5 mg.

The "four extra essentials" of hemapoiesis; exclusive with ROETINIC.

for all treatable anemias: 1 ROETINIC capsule daily

Bottles of 30 and 100 soft-gelatin capsules. On your prescription only.

***Trademark**

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CHICAGO 11, ILLINOIS

NEW- MAJOR ADVANCE IN ADRENOCORTICAL THERAPY

COMPARED WITH TOPICAL HYDROCORTISONE (COMPOUND F)

'ALFLORONE'

EFFECTIVE IN 1/10TH THE CONCENTRATION

'ALFLORONE'

SIGNIFICANTLY CUT THE COST OF THERAPY

'ALFLORONE'

A SIMILAR WIDE MARGIN OF SAFETY

Indications: Therapeutic range of ALFLORONE is essentially the same as topical forms of hydrocortisone (Compound F).

Supplied: Topical ointments of ALFLORONE Acetate (Fludrocortisone Acetate, Merck) 9, alpha-Fluorohydrocortisone Acetate; now available . . . in 5-Gm. and 15-Gm. tubes in concentrations of 0.1% *and* 0.25% in an emollient base.

SHARP & DOHME

Division of Merck & Co., Inc.

Based on clinical evidence, weight for weight, ALFLORONE is the most effective anti-inflammatory agent yet developed for topical use.

XUM

Letters

V.A. hospitalization called socialistic • Too much publicity about fee splitting? • In defense of Viennese professors • How to choose a location • Foreign sports cars for professional use

Labor Health Plans

SIRS: Your article on labor's health centers is a very important contribution. A great deal of public education is needed—and not for labor alone—on the subject of these "complete" health plans. Some of our intellectuals don't seem able to understand the differences between open and closed panel systems of medical care. Nor, apparently, can they define the word "monopoly" as it applies to *all* spheres of socio-economic activity.

Michael S. Shea, M.D.
New Haven, Conn.

SIRS: Labor groups aren't the only ones that have set up their own clinics and hospitals, with comprehensive prepaid medical care plans for their members. There are lesser forces at work toward the same end: management, professional and white-collar groups, civic and municipal groups, cooperatives, fraternal and welfare organizations, insurance companies, and a number of Congressmen.

As a result, we're sure to see an increase in comprehensive prepayment medical care plans during the next few years—and an increase, as well, in group practice clinics, which seem the best means of purveying medical care under such plans.

Harry B. Davidson
Manager, The Joslyn Clinic
Maywood, Ill.

SIRS: Speaking of labor health centers: The average income in New York City's garment industry is less than $60 a week. Thus, the garment worker can't afford to pay for private medical care; instead, he goes to the union's free clinic. He doesn't worry about free choice of physician. Why should *he* see any evil in the closed-panel plan?

Unless organized medicine can meet *this* challenge, organized labor will continue to carry the torch for closed-panel systems.

M.D., Missouri

SIRS: Your recent article, "Labor Demands Full Coverage—at Doc-



New

For ESSENTIAL HYPERTENSION

an alliance of the classic and contemporary . . .

THEOMINAL R.S.

(Theominal with Rauwolfia serpentina)

Combines for synergistic action:

Theobromine	*(5 grains) 0.32 Gm.*
Luminal® (pioneer brand of phenobarbital)	*(1/6 grain) 10 mg.*
Rauwolfia serpentina alkaloids (alseroxylon fraction)	***1.5 mg.***

Theominal itself has been widely prescribed for essential hypertension for several decades. The addition of Rauwolfia serpentina alkaloids—purified alseroxylon fraction—to the well established Theominal formula represents a substantial improvement.

With the use of Theominal R.S., objective and subjective improvement can be obtained in a large percentage of hypertensive patients. There is mild and gradual but sustained reduction of excessive blood pressure and pulse rate to near normal levels. Striking symptomatic improvement occurs concurrently: alleviation of congestive headache, vertigo, dyspnea, nervous irritability, apprehension and insomnia.

With Theominal R.S. medication the antihypertensive action of Luminal and theobromine may be evident in a few days, whereas a week or more may elapse before the Rauwolfia component exhibits its maximum effectiveness. However, the sense of well being due to Rauwolfia is experienced within a few days of medication and usually precedes the development of the maximum antihypertensive effect. Theominal R.S. is well tolerated.

DOSAGE: The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until its resumption is indicated.

HOW SUPPLIED: Theominal R.S. is supplied in bottles of 100 tablets.

Also available as before

THEOMINAL (Each tablet contains theobromine 0.32 Gm. and Luminal 32 mg. and

THEOMINAL (M) (Each tablet contains theobromine 0.32 Gm. and Luminal 15 mg.)

WINTHROP

Winthrop-Stearns Inc.
New York 18, N. Y. Windsor, Ont.

Theominal and Luminal, trademarks reg. U. S. Pat. Off.

XUM

tors' Expense," is the most encouraging evidence to date that medicine still has clear-thinking and courageous leadership . . . Congratulations to Drs. Earl W. Burgner and Millard C. Beyer of the Summit County (Akron) Medical Society for refusing to accept a union-sponsored service-type fee program. They've proved their belief that principle is more enduring than expediency, that appeasement leads to more appeasement, and that freedom is lost by small surrenders.

James M. Neil, M.D.
Oakland, Calif.

Crowded Waiting Rooms

SIRS: To the woman who accuses doctors of purposely keeping their offices crowded, in order to impress patients:

May I suggest that if most patients took up less of the physician's time talking about irrelevant social and political matters, he'd be able to keep on schedule and do away with the crowds?

I. A. Fond, M.D.
Chicago, Ill.

Segregation in Offices

SIRS: I was surprised and disappointed when I examined the architect's floor plan that illustrates "A Well-Planned Office for a Family Doctor." Not only have you shown poor taste in choosing a plan that blatantly displays separate reception rooms for Negro and white patients; but, in presenting the story as you do, you're also guilty of condoning and fostering racial segregation.

Beatrice K. Schreibman, M.D.
Philadelphia, Pa.

The editors of MEDICAL ECONOMICS *present the facts as they find them, not as they'd like them to be. And, rightly or wrongly, many Southern doctors do have two reception rooms.*—ED.

No Socialism!

SIRS: The American Legion violates every known precept of American fighting men when it encourages socialism via "free" hospitalization for non-service-connected disabilities.

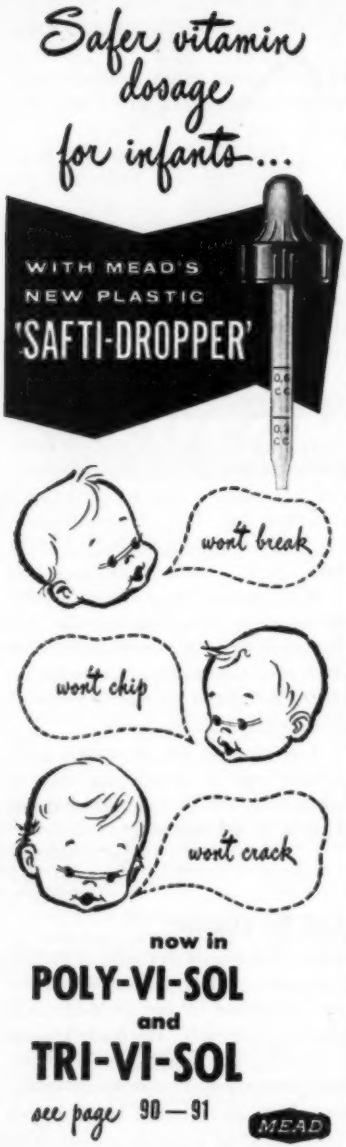
What could be more socialistic than having the Government and the taxpayer furnish medical benefits for persons who have not incurred their disabilities in the defense of our country? . . .

Though I'm an insurance consultant, not a doctor, I'd like to salute the A.M.A. for opposing the Legion in this respect.

Ray T. Wright
Lawrence, Kan.

Call Me Doctor

SIRS: "M.D., Wisconsin" suggests "that the right to call oneself 'Doctor' be limited by law to M.D.s and perhaps dentists." He doesn't seem to realize that members of such allied professions as veterinary medicine have contributed much to *his*



profession. We have a legal—and, I believe, a moral—right to the title . . .

Robert H. Fitts, D.V.M.
Chagrin Falls, Ohio

SIRS: When I was in medical school twenty-five years ago, we freshmen were properly deflated by our professor of chemistry, Allan Winter Rowe, Ph.D. Said he, with pseudo contempt (I think): "A doctor is a learned man. A physician is a healer of the sick."

John F. Connell, M.D.
Elmhurst, N.Y.

SIRS: . . . By common consensus, not by class pride, clergymen are often referred to as doctors, even though they don't always hold the D.D. degree. If a congregation were denied the joy of calling their pastor "Doctor," they would be most unhappy. This is obviously a situation that legislation cannot change.

Another point: Medicine is a relatively new profession, while theology is the second oldest profession. Before there were doctors of medicine, there were "doctors of the church."

Bachelor of Divinity
Connecticut

Fee-Splitting Talk

SIRS: Hats off to Dr. E. D. Urban, who pleads for less talk in the lay press about fee splitting, about G.P. vs. specialist, etc. It's high time someone spoke up against the small but noisy number of self-appointed

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...it's IRON-PLUS

...it's SMALLER than a dime

naturally, it's...

...it's now only 2-A-DAY

...it's more ECONOMICAL

new Iberol®



filmtab*

*T.M. for Abbott's film-sealed tablets; pat. applied for.

48

new **Iberol**

the IRON-PLUS formula

2 Filmtabs contain:

Elemental Iron (*as Ferrous Sulfate*)	210 mg.	THE RIGHT AMOUNT OF IRON
+		
BEVIDORAL® (*Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott*)	1 U.S.P. Oral Unit	ANTI-PERNICIOUS ANEMIA ACTIVITY
+		
Folic Acid	2 mg.	ESSENTIAL NUTRITIONAL FACTORS
Ascorbic Acid	150 mg.	
Liver Fraction 2, N.F.	200 mg.	
Thiamine Mononitrate	6 mg.	
Riboflavin	6 mg.	
Nicotinamide	30 mg.	
Pyridoxine Hydrochloride	3 mg.	
Pantothenic Acid	6 mg.	

new **Iberol**

now 2-A-DAY dosage

Therapeutic dose for iron-deficiency, nutritional and pernicious anemias is now only 2 tablets daily. For prophylaxis in anemias of old age, pregnancy, and convalescence (particularly in post-gastrectomies): 1 or more daily.

new **Iberol**

SMALLER than a dime

Because of the new *Filmtab* (marketed only by Abbott), new IBEROL provides —for the first time in a tablet of its size—the basic antianemia agents plus essential nutritional factors, including the *complete* B complex. Tasteless; a hard tablet, not a soft capsule.

new **Iberol**

now more ECONOMICAL

Dosage supply of 2-a-day IBEROL *Filmtabs* now lasts 50% longer than the previous 3-a-day treatment—and the savings are passed on to your patient! Potent new formula provides increased antianemia activity . . . eliminates need for added B-complex.

Abbott

public washers of the medical profession's dirty linen. Such persons have convinced many Americans that every doctor (except, naturally, the speakers) is a money grabber, a skinflint, and a heartless crook. It is sometimes hard to believe they're acting in good faith . . .

William S. Hitrec, M.D.
Floyd, Va.

D.O. Into M.D. by Law?

SIRS: Anyone with half a mind can see the logic in Dr. Harold E. Petersen's plan to obtain equal licensure for M.D.s and D.O.s in Missouri. There are so many D.O.s in the small rural communities of our state that the M.D. is compelled to consult with the cultist in many areas. So it's logical to do away with cultism and give everyone in Missouri first-rate medical care.

But exactly how, I ask, do you legislate the cultist into a first-rate doctor?

Orville L. Dawson, M.D.
St. Joseph, Mo.

All's Well in Vienna

SIRS: In his comments on your picture story, "American in Vienna," Dr. Bernard Wagner calls the professors there "arrogant and contemptuous of foreigners."

I'm sincerely sorry that such a remark was allowed to appear in MEDICAL ECONOMICS. I have been doing post-graduate work at the University of Vienna since June, 1954, and I'm particularly happy to



FIRST COMPLETE FORMULA

EXPRESSLY

FOR THE COUGHING PATIENT

relieves cough "tickle," quiets "hack"

curbs congestive symptoms

patients feel better, sleep better

relieves aches and pains

valuable in allergic or bronchial coughs

new CORICIDIN syrup

tastes good—an ideal vehicle

Each teaspoonful (5 cc.) of CORICIDIN Syrup* contains:

Dihydrocodeinone bitartrate	1.67 mg.
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Sodium salicylate	225.0 mg.
Sodium citrate	120.0 mg.
Caffeine	30.0 mg.
Glyceryl guaiacolate	30.0 mg.

combined in a delicious, compatible syrup acceptable to all ages.

Dosage: Adults: One teaspoonful initially followed by another teaspoonful in one hour. Thereafter one teaspoonful three to four times daily.

Children: One-half adult dosage for those 6-12 years old. Children under 6 years according to age or body weight.

*Exempt narcotic.

CORICIDIN,® brand of analgesic-antipyretic compound.
CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.

Schering



CORICIDIN Syrup

say that I have observed nothing but friendly cooperation and courtesy.

Allen H. Moore, M.D.
Vienna, Austria

SIRS: . . . Nowhere have I been treated with more courtesy and friendliness than in Vienna, from which I've just returned. I earnestly recommend the post-graduate school there to anyone who wants to avail himself of excellent teaching facilities and, at the same time, to enjoy a pleasant and unhurried life in a beautiful—and very inexpensive—city.

Kurt C. Springer, M.D.
Kankakee, Ill.

SIRS: Last September, I spent about five days meeting a number of top professors in Vienna. These professors appeared to be altruistic, benevolent, and full of tutorial generosity . . .

Peter A. Delmonico, M.D.
Belmont, Mass.

Degrees on Letterheads

SIRS: I cannot agree with Dr. Richard H. Sherwood that degrees like B.A. and B.S. belong on a doctor's letterhead. Many M.D.s get these academic degrees in a package deal, after a couple of years of premedical training and a year or so in medical school; so they're hardly a mark of distinction.

But I *do* agree that it's silly to include initials showing specialty society affiliation on stationery. A man of status doesn't have to resort to such gimmicks . . . Wouldn't it be equally logical to add mention of affiliation with the A.M.A., the state and county medical societies, the Elks, Odd Fellows, Masons, Knights of Columbus, etc.?

Hans Schroeder, M.D.
San Francisco, Calif.

Choosing an Office Site

SIRS: In your article on choosing an office site, you stressed, rightly, the importance of locating near public transportation. In my experience, easy accessibility should outweigh most other considerations. Here's an example to prove my point:

One of my doctor-clients, who'd been practicing in a centrally located office building, found he'd have to move when the building was sold to a large company. He had his heart set on a "prestige" location near the university, several blocks away from the nearest bus line. During the next few weeks, he asked all the patients who came to his office whether they'd be willing to follow him to the chosen location. Without exception, they said yes.

But I suspected they weren't telling him the truth, simply because they didn't want to hurt his feelings. So, at my suggestion, he wrote letters to all his patients, listing five possible office sites and asking them to check their first, second, and third choices. Out of hundreds of replies, only two or three showed any preference for the "prestige" location. As a result, the doctor moved to an-

XUM



therapeutic bile

in liver and gallbladder disorders

"...due to the production of true hydrocholeresis—
a marked increase both in volume and fluidity of the bile."*

"...the objectives of the principal therapy cannot but be furthered...."*

"...confirmed further by the clinical experiences reported."*

DECHOLIN® and DECHOLIN SODIUM®

(dehydrocholic acid, *Ames*) (sodium dehydrocholate, *Ames*)

Decholin Tablets, 3¾ gr. (0.25 Gm.); bottles of 100, 500, 1000. *Decholin Sodium*, 20% aqueous solution; ampuls of 3 cc., 5 cc. and 10 cc.; boxes of 3, 20 and 100.

Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. 16:102, 1953.

AMES COMPANY, INC · ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

other office in the center of the city.

But he still wasn't satisfied. Later, he established a part-time office at the "prestige" location. In six months there, he didn't see enough patients to pay for one month's rent. That, of course, settled the matter.

J. P. Revenaugh
Professional Business Management
Chicago, Ill.

Right Was Wrong

Sirs: In reading your October article, "The Car You Drive" (a very interesting job, by the way), I notice that the cut on page 102 shows two cars with steering wheels on the right. I dare say you've had ample notice of this error by now.

But the subject of right-hand drive brings up a question that might interest students of the MEDICAL ECONOMICS automobile survey. How do doctors feel about sports cars and small cars, both foreign and domestic?

My own guess (100 per cent impartial, and based on induction, not observation) is that the small size and maneuverability of such cars should make them favorites with doctors who have traffic and parking problems to contend with. Right?

Thomas L. Cooper
Philadelphia, Pa.

The artist who sketched those right-hand-drive cars may have drawn



For HARD, DRY STOOLS OF CONSTIPATED BABIES

Borcherdt

MALT SOUP Extract*

A gentle laxative modifier of milk. One or two tablespoonfuls in the day's formula—or in water for breast fed babies—produce a marked change in the stool.

SAVES DOCTOR'S TIME, TOO!

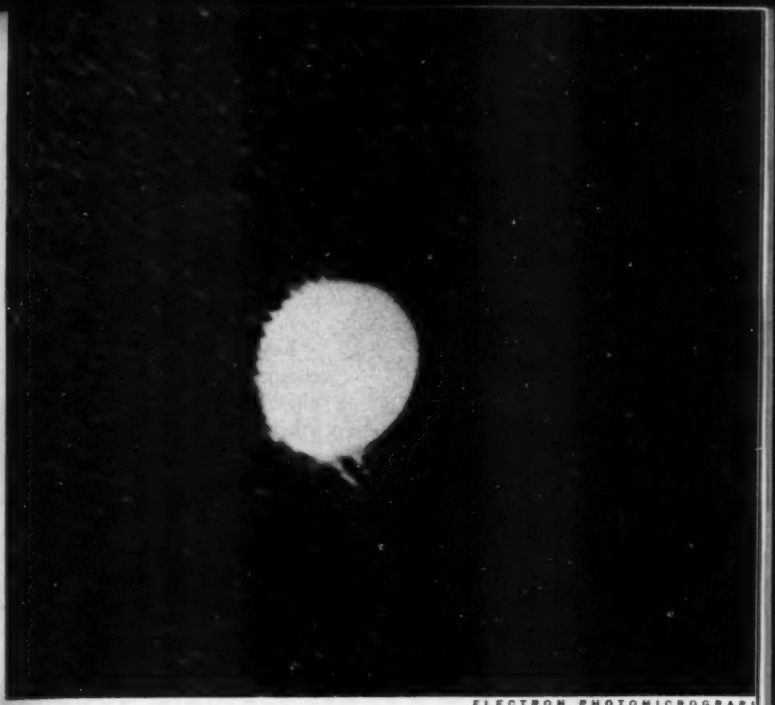
Fewer phone calls from anxious mothers. Malt Soup Extract is merely added to the formula. Prompt results. Easy for mother to prepare and administer. Does not upset the baby.

*Specially processed non-diastatic malt extract neutralized with potassium carbonate. In 8 oz. and 16 oz. bottles.

Send for Samples and Literature

BORCHERDT MALT EXTRACT CO.
217 N. Wolcott Ave. • Chicago 12, Ill.

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ELECTRON PHOTOMICROGRAPH

Staphylococcus aureus 35,000 X

Staphylococcus aureus (Micrococcus pyogenes var. aureus) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis
septicemia • bronchopneumonia • bronchiectasis
tracheobronchitis • and food poisoning.

It is another of the more than 30 organisms susceptible to

PANMYCIN*

100 mg. and 250 mg. capsules

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

them that way as an unconscious expression of deep-seated Anglophilia, or simply to see how many readers he could arouse. If for the latter reason, his success is attested by the number who have notified us of the "error."

On the question of small cars (including sports cars) for professional use, we'll be glad to open these columns to physicians' comments.—ED.

Is It Fair?

SIRS: My turn to apply to medical schools came in 1947, and again in 1948. At that time, as you know, there were thousands of applicants in excess of the capacity of the schools. I was one of that excess; so, instead of turning to salesmanship as a career, I went to a European institution, in a country whose schools are now on the approved list.

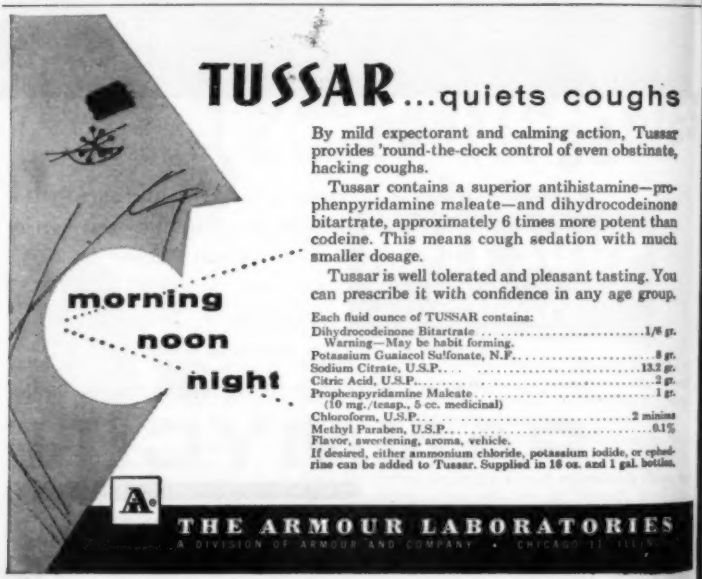
I graduated high in my class and returned to these shores full of hope. I served an excellent interneship in a New York hospital, and then came to Colorado for a residency in surgery.

Result? I'm now informed by competent authorities that I'm ineligible to practice in this and most other Western states—though I'm a native-born American—simply because I hold a European diploma.

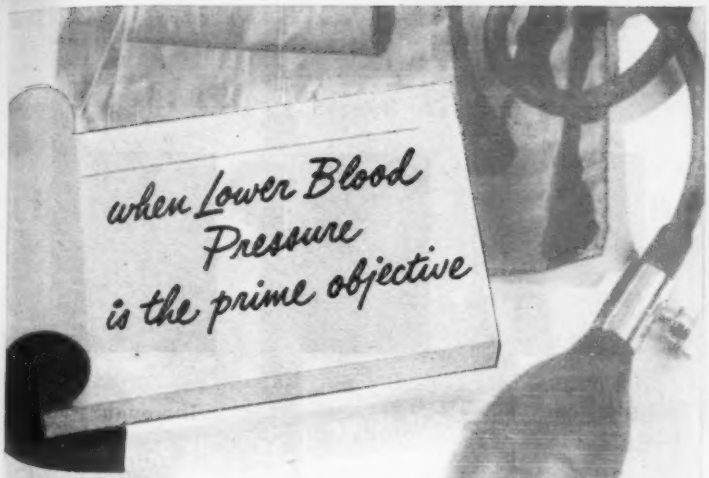
Is that fair?

N. Ronis, M.D.
Denver, Colo.

END



XUM



UNITENSEN® tannate TABLETS

brand of cryptenamine

IS THE MOST DEPENDABLE HYPOTENSIVE DRUG YET DEVELOPED

Whatever the collateral therapy in moderate to severe hypertension, the therapeutic objective is far more than tranquility or euphoria. The prime objective is to lower blood pressure.

Unitensen is a potent, true blood pressure lowering agent . . . the safest and most significant yet developed. Unitensen contains cryptenamine, a newly isolated alkaloid fraction of Veratrum viride. In the majority of patients, Unitensen produces positive and sustained blood pressure control.

UNITENSEN

- decisively controls blood pressure for prolonged periods
- no sympatholytic or parasympatholytic action
- no postural hypotension and collapse
- no ganglionic blocking
- renal function is not impaired
- free from dangerous side actions
- duo-assayed for hypotensive action and emesis
- simplified dosage—usually 1 tablet b.i.d. or t.i.d.
- saves money for your patients

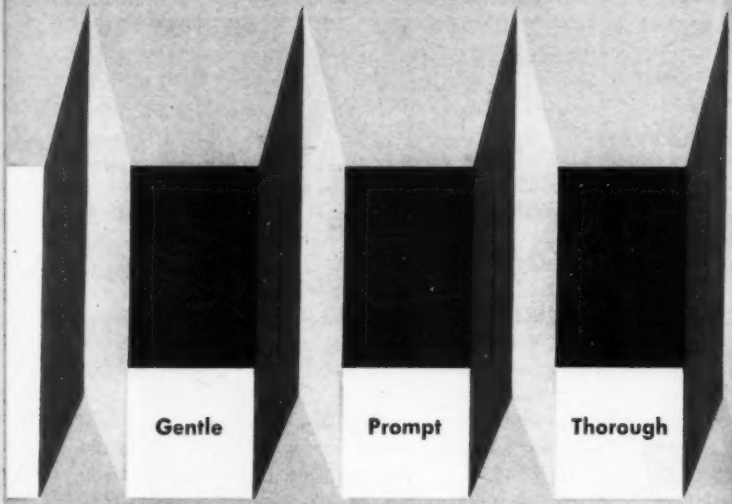
Each white, uncoated, scored tablet supplies:

Cryptenamine*. . . .2 mg.†
(as the tannate salt)

*ester alkaloids of Veratrum viride obtained by an exclusive Irwin-Neisler nonaqueous extraction process.
†equivalent to 280 Carotid Sinus Reflex Units.

Bottles of 50, 100, 500 and 1000.

IRWIN, NEISLER & COMPANY • DECATUR, ILLINOIS



PHOSPHO-SODA (Fleet)®

Notably safe and effective for half-a-century

As a laxative of choice: 2 teaspoonfuls before breakfast or other meals, if indicated.

As a purgative of choice: 4 teaspoonfuls or more before breakfast.

Administer in one-half glass of water, followed by second glass.

Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 Gm. and sodium phosphate 18 Gm.

C. B. Fleet Co., Inc. • Lynchburg, Virginia

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the new **FLEET ENEMA** in the disposable unit

Also gentle • prompt • thorough

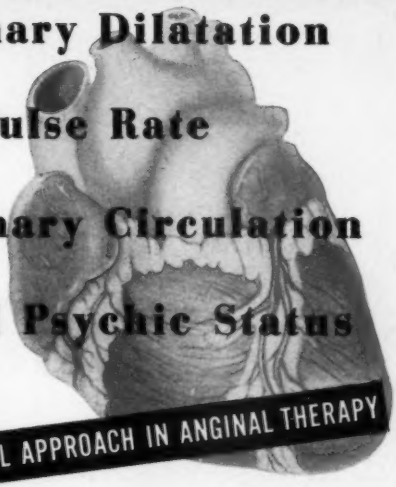
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Lower Pulse Rate

Better Coronary Circulation

Improved Psychic Status



THE NEW, MORE SUCCESSFUL APPROACH IN ANGINAL THERAPY

PENTOXYLON combines the bradycrotic, tranquilizing, stress-relieving effects of Rauwiloid® 1 mg. with the prolonged coronary vasodilating influence of pentaerythritol tetranitrate (PETN) 10 mg.

Reduced heart rate lengthens diastole and leads to better coronary filling and wider stroke volume.

This new approach reduces nitroglycerin need, in many instances obviates it; increases exercise tolerance, reduces anxiety, allays apprehension, and produces objective, ECG-demonstrable improvement.

• • •

Dosage: one to two tablets q.i.d. In bottles of 100 tablets.

PENTOXYLON™

Each tablet contains pentaerythritol tetranitrate (PETN) 10 mg. and Rauwiloid® 1 mg.

Equally indicated in normotensive and hypertensive patients, since Rauwiloid lowers elevated blood pressure but does not affect normal tension.

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

Enriched Bread

a Valiant Guardian Against Deficiency Disease



As a result of the nationwide enrichment of bread, the average American consumes notably more thiamine, riboflavin, niacin, and iron.[1] Enriched bread has thus served as a vigilant guardian against beriberi, ariboflavinosis, pellagra, and iron-deficiency disease.[2]

According to calculated values, the food supply of the nation during 1942-1948 provided 25 per cent more thiamine, 10 per cent more riboflavin, 15 per cent more niacin, and 14 per cent more iron than it would have without the nationwide enrichment of bread and flour.[3,4]

In consequence of this nutritional enhancement of the nation's food supply, enriched bread has been a material aid in improving national nutritional health.[2,4,5,6]

Enriched bread also supplies important amounts of high-grade protein, calcium, and nutrient energy. Its protein, comprising flour protein and milk protein, contributes significantly to sound growth and tissue maintenance.

1. Groggins, P.H.: The High Price of Eating Well, J. Agr. & Food Chem. *1*:1124 (Nov. 25) 1953.
2. Sebrell, W.H., Jr.: Trends and Needs in Nutrition, J.A.M.A. *152*:42 (May 2) 1953.
3. Nutrients Available for Consumption per Capita per Day, 1909-1948, United States Department of Agriculture, Miscellaneous Publication 694, 1949.
4. Jolliffe, N.: The Pathogenesis of Deficiency Disease, in Jolliffe, N.; Tisdall, F.F., and Cannon, P.R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1951, chap. 1.
5. Flour and Bread Enrichment, 1949-50, The Committee on Cereals, Food and Nutrition Board, National Research Council, 1950.
6. Sherman, H.C.: The Nutritional Improvement of Life, New York, Columbia University Press, 1950, pp. 86-87.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN BAKERS ASSOCIATION

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XUM



ELECTRON PHOTOMICROGRAPH

Diplococcus pneumoniae 35,000 X

Diplococcus pneumoniae (Streptococcus pneumoniae) is a Gram-positive organism commonly involved in

lobar—and bronchopneumonia • chronic bronchitis • mastoiditis
sinusitis • otitis media • and meningitis.

It is another of the more than 30 organisms susceptible to

PANMYCIN*

[redacted]

100 mg. and 250 mg. capsules

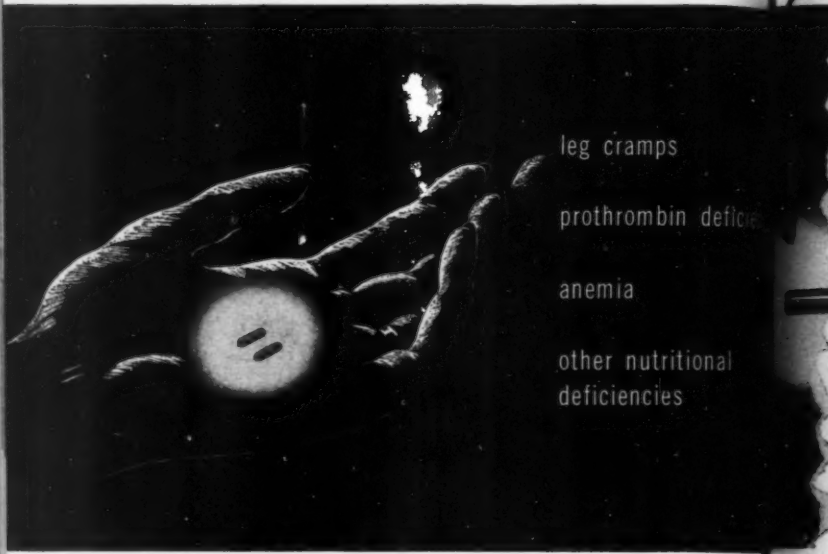
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Upjohn

XUM

Help prevent

these complications of Gestation



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PROVIDE: • **PHOSPHORUS-FREE CALCIUM**
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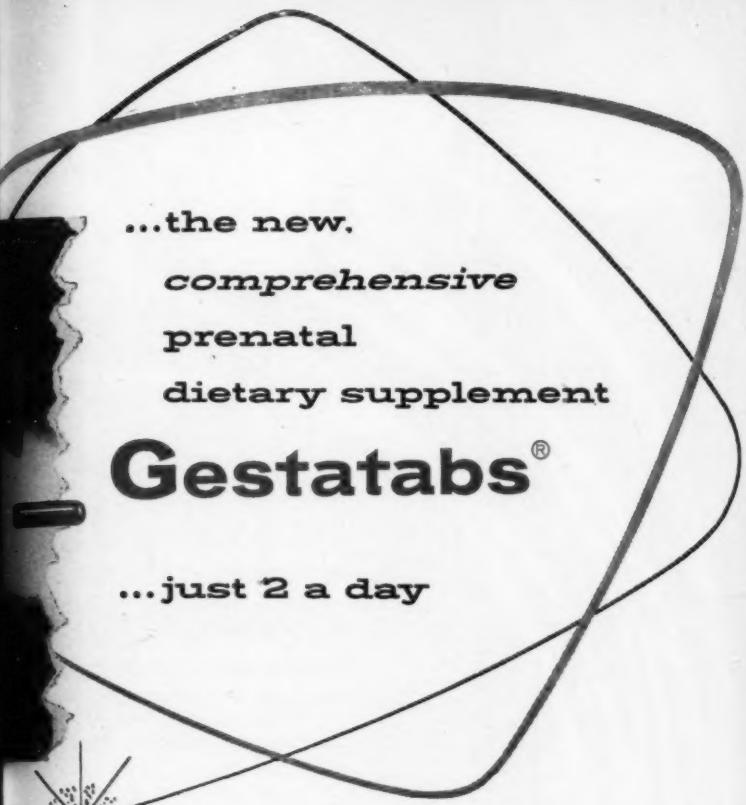
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• substantial amounts of essential vitamins including vitamins A, C, D, Vitamin B_{12} and other B vitamins.

WHITE LABORATORIES, INC., Kenilworth, N. J.

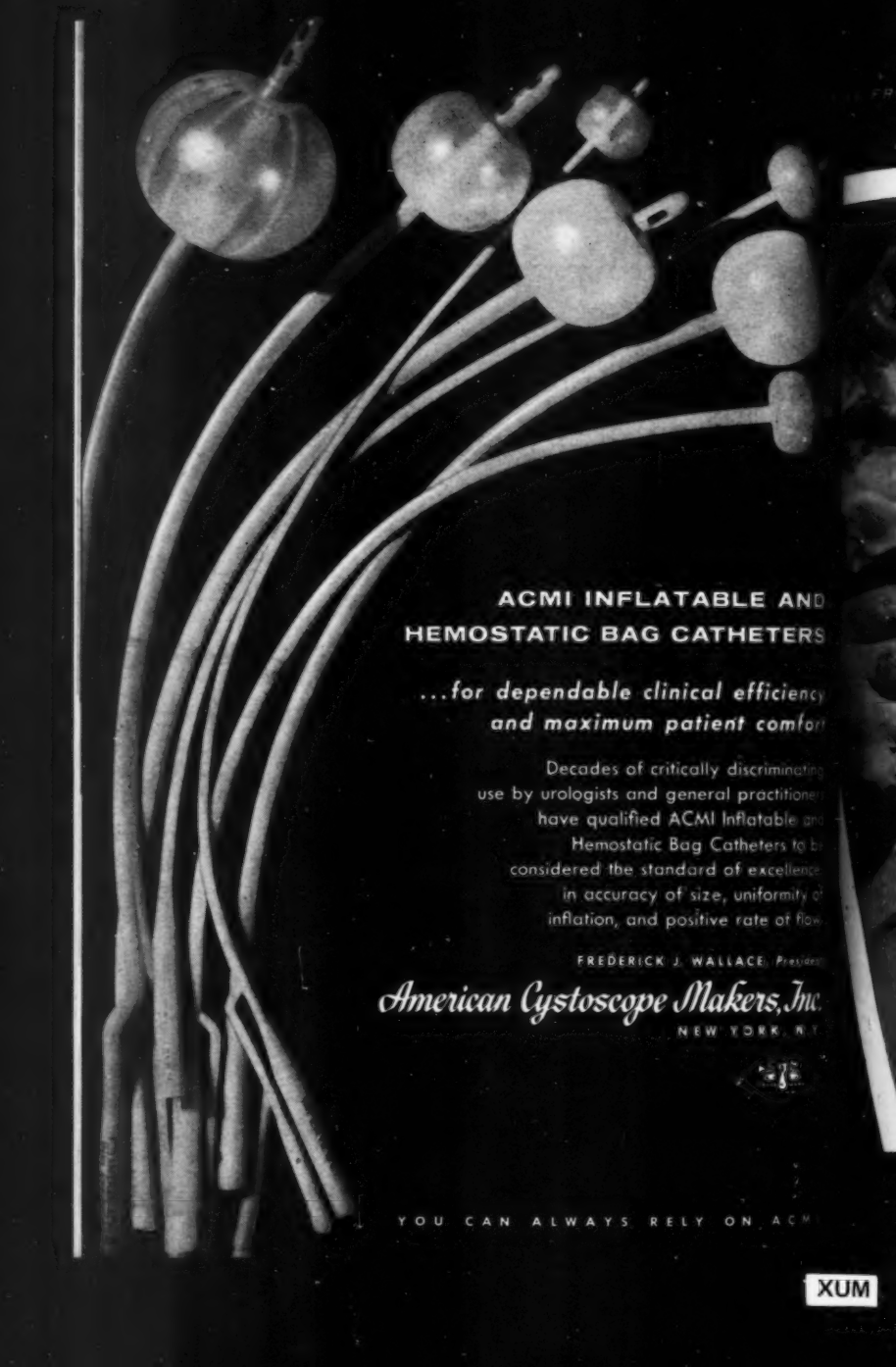
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JUST 2 TABLETS DAILY PROVIDE:

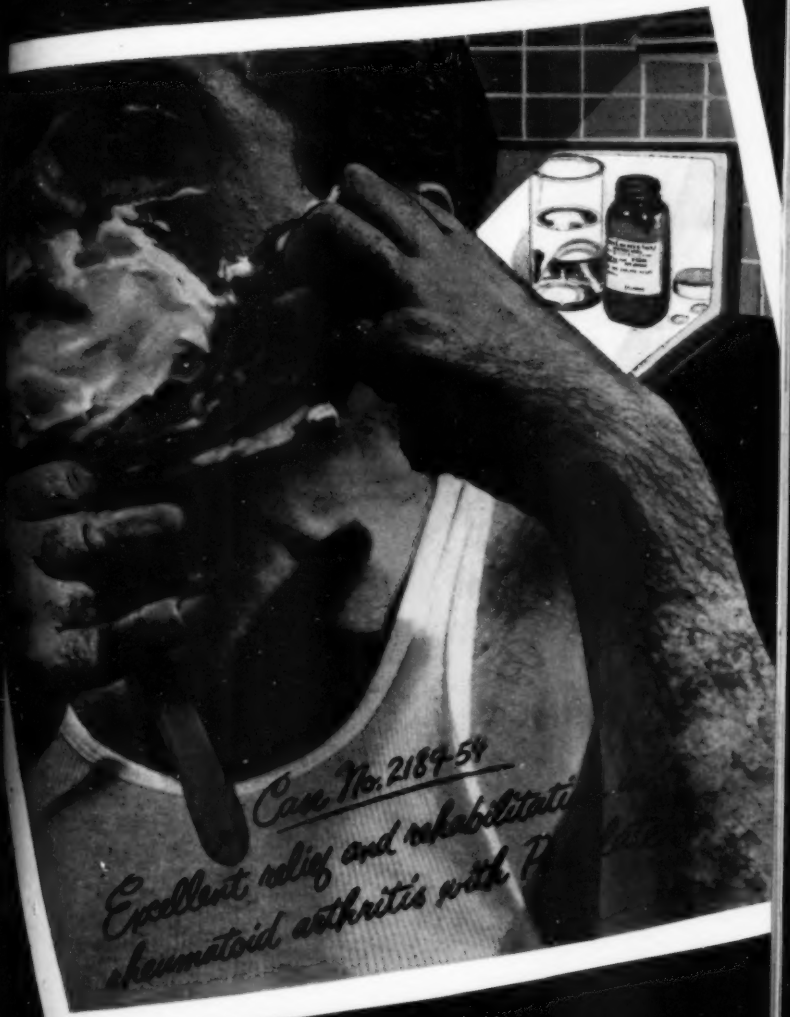
Vitamin A	6,000 U.S.P. Units
Vitamin D	600 U.S.P. Units
Vitamin K (menadione)	2 mg.
Vitamin B_{12} Activity Equivalent*	2 mcg.
Folic acid	1 mg.
Ascorbic acid	100 mg.
Thiamine mononitrate	3 mg.
Riboflavin	5 mg.
Pyridoxine hydrochloride	1.5 mg.
Calcium pantothenate	10 mg.
Nicotinamide	30 mg.
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Ferrous sulfate	120 mg.
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Calcium (elemental)**	380 mg.

*As in Streptomyces fermentation extractives.
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"'round-the-clock", by stimulating
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Pabalate-Sodium Free is the preferred
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Free from adverse reaction.

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RHEUMATOID ARTHRITIS

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Pabalate
Each yellow enteric coated tablet contains sodium salicylate U.S.P. 0.3 Gm. (5 gr.), para-aminobenzoic acid (as the sodium salt) 0.3 Gm. (5 gr.), and ascorbic acid 50 mg.

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Now... a choice of 2 forms for truly effective COUGH therapy

ROBITUSSIN®

"The effective cough medicine of choice"[2] with documented[1,2] superiority.

Glyceryl guaiacolate.....100 mg. —most powerful of all expectorants, increases RTF almost 200%.

Dextromethorphan HBr ..... 10 mg. —relieves bronchial spasm while improving the mood of the cough-weary patient.

—in a highly palatable syrup vehicle

A new form...

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(Robitussin with Antihistamine and Codeine)

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Pheniramine maleate ..... 12.5 mg. —a potent antihistamine, noted for its freedom from side effects.

Codeine phosphate ..... 10 mg. —the first choice of cough suppressants, highly effective, yet non-addictive.

EXEMPT NARCOTIC

tastes wonderful!



REFERENCES: 1. Blanchard, E. and Ford, R. A., Effective Antitussive Agent in the Treatment of Cough in Childhood, Journal-Lancet, 74:443, Nov., 1954. 2. Cass, L. J. and Frederik, W., Comparative Clinical Effectiveness of Cough Medication, Amer. Pract. and Dig. of Treat., Vol. 2, p. 844, October, 1951.*

*Reprints available upon request.

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Containing two effective expectorants—ammonium chloride and sodium citrate—it produces rapid non-irritating action. It has a high degree of gastric tolerance and palatability which makes it acceptable to both adults and children.

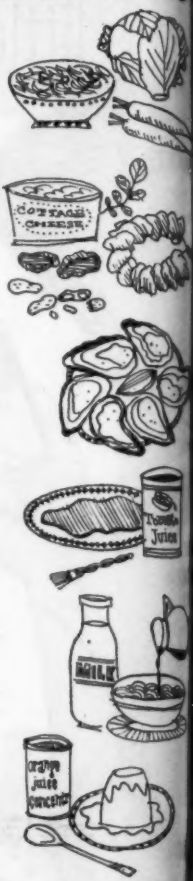
Active Ingredients: Sodium Citrate, Ammonium Chloride, Glycerin, Cetamium (Vick brand of cetylpyridinium chloride) in a pleasantly flavored syrup containing Eucalyptus, Menthol. Camphor, and other Vick aromatics.

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MEDI-TRATING
COUGH SYRUP

Made by the makers of Vicks VapoRub

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High-Vitamin, High-Mineral Diet the natural way!



Foods high in vitamins and minerals can provide your patient with good nutrition naturally. And these "diet do's" may tempt him to rely more on food than supplements for his vital nutrients.

These foods are best served raw—

Shredded new cabbage and carrot slaw combines the benefits of vitamins A and C with some calcium.

Dried apricots and figs prettily stuffed with cottage cheese and peanuts provide calcium, iron, vitamins A, B_2, niacin, and C.

Oysters, exceptionally rich in iron and calcium, carry vitamins A and D as well.

These good foods can be made even better—

Beef liver ranks high in iron, vitamins A, and B-complex. Brushed with tomato juice before cooking, it's tender and tasty.

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Custard contains calcium and vitamins A, B_1, and B_2. A topping of orange juice concentrate adds a bonus in vitamin C.

Of course, other micronutrients are important, too. And a varied diet will help your patient get the vital body regulators he needs.

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Beer—America's Beverage of Moderation

An 8-oz. glass of beer contains 10 mg. calcium, 50 mg. phosphorus, 1/8th minimum daily requirement of niacin, and smaller amounts of other B-complex vitamins.*

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*Average of American beers



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...types resistant to other therapy—where nerve root inflammation is not caused by mechanical pressure[1]

COMPLETE RELIEF OF PAIN

in 80.7% of patients...
52.9% in 5 days[1]



ROTAMIDE® for HERPES ZOSTER

...even cases unresponsive to a wide variety of other ...dications[2]

GOOD TO EXCELLENT RESULTS

in 82.7% of patients in two studies...
70.4% with 5 injections or less[2,3]

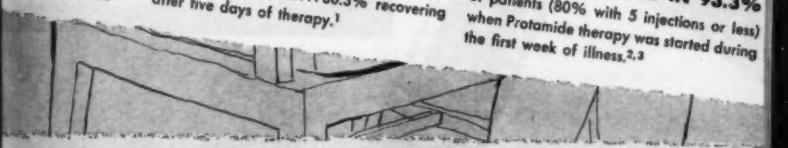


...OTAMIDE®
...ST

...early as possible in ...ses of the illness

***In Neuritis*—COMPLETE RECOVERY IN 100%** of patients when Protamide therapy was started not later than the fourth day of illness... 80.3% recovering after five days of therapy.[1]

***In Herpes Zoster*—GOOD TO EXCELLENT RESULTS IN 93.3%** of patients (80% with 5 injections or less) when Protamide therapy was started during the first week of illness.[2,3]



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PROTAMIDE is a sterile colloidal solution of processed and denatured proteolytic enzyme obtained from the glandular layer of fresh hog stomach. It is supplied in boxes of ten 1.3 cc. ampuls, and the usual dosage is 1 ampul daily by intramuscular injection. Available through your regular source of supply.

REFERENCES:
1. Smith, R. T.: New York Med. 8:16, 1932. 2. Combes, F. C. & Canizares, O.: New York St. J. Med. 32:706, 1932. 3. Marsh, W. C.: U.S. Armed Forces M. J. 1:1045, 1930.

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your patients get high blood levels in 2 hours or less

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Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

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Phosphorated Carbohydrate Solution



A unique formula for *oral* administration . . . containing no drugs likely to induce untoward effects . . . and stabilized at an optimally adjusted pH, EMETROL has proved dramatically effective in epidemic and other types of functional vomiting.[1-3] In an 18-month study, Bradley and associates obtained excellent responses in 172 children, often with a single dose of 1 to 3 teaspoonfuls. EMETROL is easy and pleasant to take, safe for all age groups.

IMPORTANT: EMETROL must always be taken *undiluted.* No fluids should be allowed for at least 15 minutes after each dose.

DOSAGE: For infants and children, 1 or 2 teaspoonfuls every 15 minutes until vomiting stops. For adults, 1 or 2 tablespoonfuls.

SUPPLIED: In bottles of 3 fl.oz. and 16 fl.oz., through all pharmacies.

In nausea of pregnancy, EMETROL has produced favorable response in 3 out of every 4 cases, usually within 24-48 hours.[2] Recommended as "free of annoying side effects . . . a safe and physiologic agent . . ."

---

1. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 2. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953. 3. Tebrock, H. E., and Fisher, M. M.: M. Times 82:271, 1954.

Literature and sample on request

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...you would find it
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KONDREMUL *Plain*—containing 55% mineral oil, bottles of 1 pt.

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highly penetrant... highly demulcent... highly palatable—no danger of oil leakage or interference with absorption of nutrients when taken as directed

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*A dynamic approach to better health for the aging patient**



IN THE 40's AND 50's

"disease or body change is lurking in the background"† even though the individual may feel in good health. In this age group "Mediatric"* will help prevent premature atrophic changes due to waning sex hormone function and inadequate nutrition.



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involutional changes become increasingly apparent as the body loses its ability to resist environmental stress. "Mediatric"* will aid the aging economy cope more successfully with three important stressors: gonadal hormone imbalance, dietary insufficiency, and emotional instability.



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†Kountz, W. B.: J.A.M.A. *153*:777 (Oct. 31) 1953.

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Steroid-nutritional compound

STEROIDS . . . to counteract declining sex hormone function
NUTRITIONAL SUPPLEMENTS . . . to meet the needs of the aging patient
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Capsules, No. 252 — bottles of 30, 100, and 1,000.
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Average dosage, 1 capsule or 3 teaspoonfuls of liquid, daily.

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	SOLUTION	mEq per 1000 cc								Carbohydrate	Route of Admin.
		Na	K	Ca	Cl	Lactate	NH_4	Mg	NPO_4		
★	Modified Duodenal Solution	80.0	36.0	4.6	63.0	60.0	—	2.8	—	—	Any
★	Travert 10%-Electrolyte No. 1	80.0	36.0	4.6	63.0	60.0	—	2.8	—	Travert 10%	Any
★	Travert 10%-Electrolyte No. 2	57.0	25.0	—	50.0	25.0	—	6.0	12.5	Travert 10%	Any
	Ammonium Chloride 2.14%	63.0	17.5	—	150.5	—	70.0	—	—	Travert 10%	Any
	Darrow's	—	—	—	400.0	—	400.0	—	—	—	IV
★	M/6 Sodium r-Lactate	121.0	35.0	—	103.0	53.0	—	—	—	—	Any
	Travert 10%-Potassium Chloride 0.3% in Water	167.0	—	—	—	167.0	—	—	—	—	Any
★	Travert 10%-Potassium Chloride 0.3% in 0.45% NaCl	—	40.0	—	40.0	—	—	—	—	Travert 10%	Any
		77.0	40.0	—	117.0	—	—	—	—	Travert 10%	Any

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In small 4-oz. size, popular 8-oz. prescription size and large 16-oz. economy size.

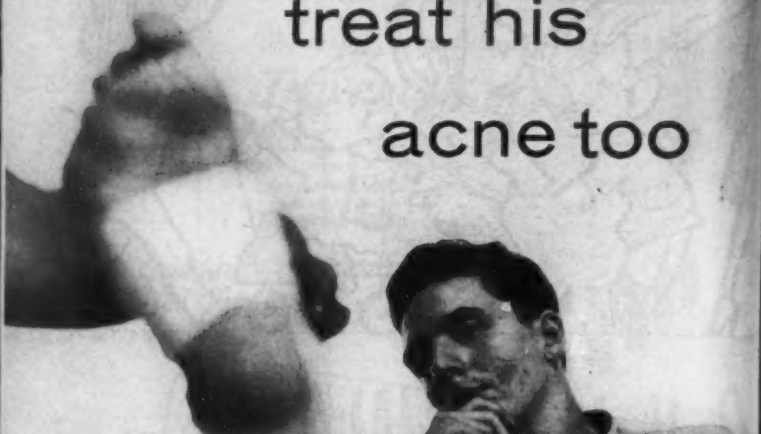
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the orange-flavored multivitamin liquid

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He came to have an ankle taped—

treat his acne too



When a teen-ager comes to you to have a sprain taped—or for any other reason—treat that acne, too. He may be too self-conscious to ask your advice, but his acne demands your skilled supervision. Under your guidance, he can be spared the scarring of skin and psyche which so often follows improper self-medication or no medication at all.

Remember 'Acnomel' when you treat acne. 'Acnomel'—resorcinol, sulfur, and hexachlorophene, in a special grease-free vehicle—brings rapid improvement in acne, often in a few days. Moreover, 'Acnomel' quickly lifts your patient's morale: its flesh-tinted base masks unsightly acne lesions and is virtually invisible when applied.

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Editorials

Do you discourage cash payment of office visit fees? • The fading specter of a national doctor shortage • Sometimes it's better not to telephone • Man with an itch becomes a security risk

Ready Cash

When a friend of ours tried to pay cash for an office visit not long ago, the physician's aide talked him out of it. "Oh, don't bother," the girl told him cheerfully. "We'll send you a statement at the end of the month."

This raises some interesting questions about office visit fees. Do people really prefer to be billed for small charges? Do doctors really prefer to bill them? If not, are there ways to encourage on-the-spot payment without actually asking for it? If so, what proportion of office patients will normally respond?

We've been collecting opinions on this subject lately; and, make no mistake, it *is* a matter of opinion. But after talking with doctors, patients, and practice management consultants, we thought you might be interested in our conclusions:

1. Many people these days would just as soon settle their obligations on the spot, as long as the amount is only a few dollars. They do it routinely during their shopping rounds; they're often prepared to do it in the medical office they may visit during the same trip.

2. Many doctors' aides discourage cash payments by the words they use—or don't use. For example, some aides never mention fees at all; thus they probably double the size of their biggest single chore: typing and mailing statements at the end of the month. They probably double the size of their employers' credit losses, too. And no doctor can truthfully say this is what he prefers.

3. Many medical offices have improved their cash collections by only small changes in routine. In one office we visited recently, the doctor writes out a charge slip and asks the patient to hand it to the receptionist. In another office, a receipt book occupies a prominent spot on the secretary's desk. In a third, the doctor's aide tells the departing patient, "The charge for today's visit is $4" —and then smiles expectantly. These discreet innovations have helped boost cash collections from $150 a month to almost $1,000, taking an

average of the three offices mentioned.

4. Fully half of all office patients can be encouraged to pay cash, according to best available evidence. They'll respond to such gentle stimulants because the idea is psychologically sound—because their appreciation of the doctor's services is keenest right after consultation or treatment.

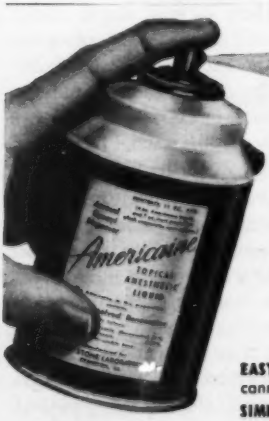
On-the-spot collections can't be built up overnight. They can't be built up at all in certain high-fee specialty practices. But many a medical man would profit by pondering the observation of our friend mentioned at the beginning of this editorial:

"I like to pay as I go, and I know lots of people who feel the same way. Why make it difficult for us?"

The Fading Specter

For years there's been agitated debate about a national doctor shortage. Medical men couldn't stop it by pointing to the increasing size of graduating classes pouring forth from existing medical schools. Reason: The population at large was increasing just as fast.

Between 1940 and 1950, for example, the total number of physicians in this country increased by 15 per cent; but the total population increased 15 per cent, too. Which



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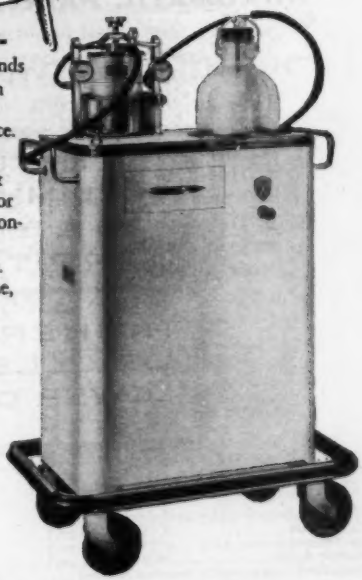
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Para-Aminobenzoic Acid... 0.25 Gm. (4 gr.)
Ascorbic Acid ..... 20.0 Mg. (⅓ gr.)
Organidin® (organically bonded iodine) ... . 10.0 Mg. (1/6 gr.)

DOSAGE:

Two tablets three or four times daily. Dosage may be increased in acute rheumatic fever.

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meant no end to the doctor-shortage controversy.

Now, at last, there's a chance the debate will diminish. During all the previous talk—in fact, during all the previous quarter-century—our medical schools remained more or less constant in number. But look what's happening today:

Two new medical schools (the University of North Carolina and the University of Puerto Rico) produced their first graduating classes within the past year. Eight more new schools (U.C.L.A., Albert Einstein, Seton Hall, and the universities of Miami, Missouri, Mississippi, West Virginia, and Florida) are gearing up for early production.

Result? "The rise in the number of medical graduates," say the statisticians, "should be relatively more rapid than general population increases in the course of the next six to ten years."

This heartening break-through doesn't solve *all* our doctor-supply problems. There's an unquestioned shortage in certain local areas and in certain key specialties. But at least the specter of a *national* doctor shortage should begin to fade.

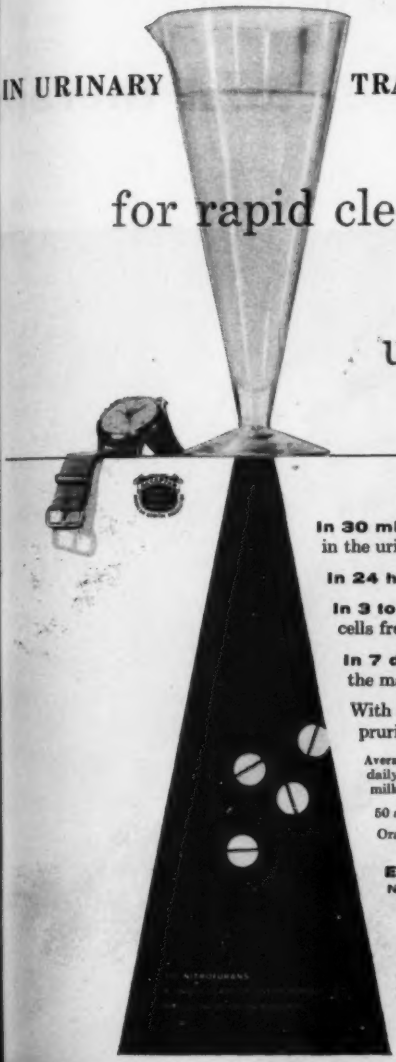
Don't Phone: Write!

Have you ever been interrupted while doing a little office surgery by an "urgent" phone call from a colleague? It happened to Dr. Clifford L. Graves of San Diego not long ago. The caller was a psychiatrist

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for rapid clearing of the urine



In 30 minutes: antibacterial concentrations in the urine

In 24 hours: the urine is frequently clear

In 3 to 5 days: complete clearing of pus cells from the urine

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With Furadantin there is no proctitis, pruritus ani, or crystalluria.

Average adult dosage: Four 100 mg. tablets daily, taken with meals and with food or milk before retiring.

50 and 100 mg. tablets.

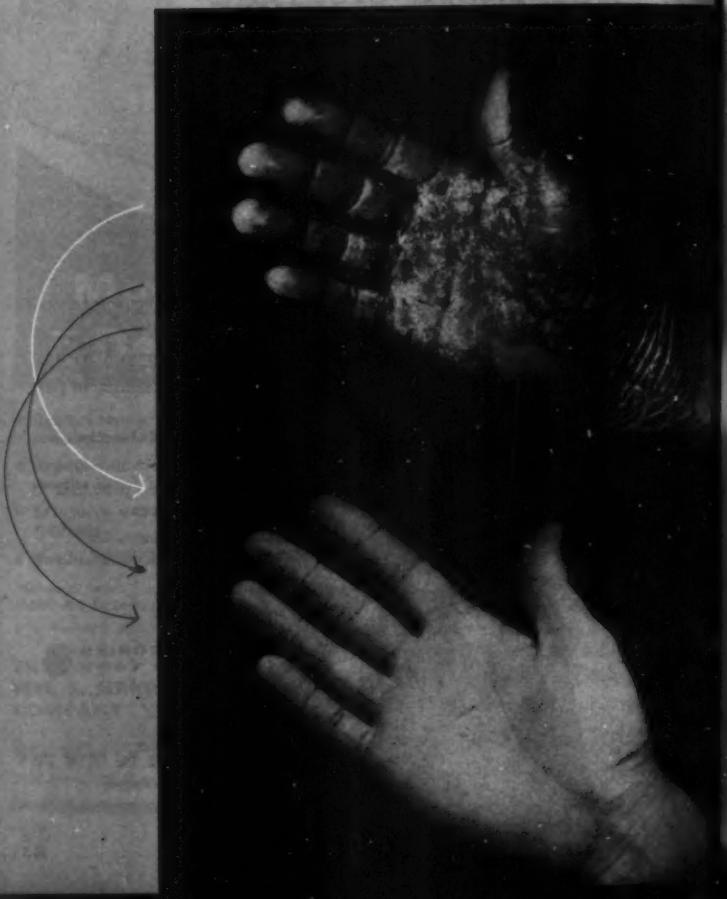
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MAZON dual therapy

Belmont Laboratories, Philadelphia, Pa.

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who had phoned earlier, while Dr. Graves was out, and had declined to leave his number because "he didn't want to be disturbed." So, Dr. Graves reports, "he disturbed *me*"—with a routine report that could easily have been sent by mail.

Telephoning seems so convenient. And it is—to the doctor placing the call. But to the doctor on the receiving end, such a call may be "an invasion of his office, a damper on his work, a break in his mental processes."

Once Clifford Graves got thinking about these things, he checked back on some of his own recent calls to colleagues. Findings? "A surprising number . . . were on matters that could have been handled equally well by mail. I was as bad as my friend, the psychiatrist!"

This useful bit of self-analysis may well apply to us all. So, too, may the San Diego doctor's solution: "Now, whenever I can, I throw my business to the post office instead of to the telephone company . . . It may require a little more effort . . . but it gives the [recipient] the freedom to take notice at *his* convenience, rather than at mine."

Federal Rules

Government must operate by rules —a necessity that does not always equip it well for handling medical

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e meal-time behavior problem, the child who shreds his mother's patience and
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stimulate appetite . . . to promote growth . . .

prescribe TROPHITE*

B_{12} plus B_1

ch Trophite' Tablet or teaspoonful of liquid 'Trophite' provides:

25 *mcg. of vitamin* B_{12}	10 *mg. of vitamin* B_1

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matters. Doctors will find new proof of this in Executive Order 10450, the Federal directive listing the findings that can lead to an employe's discharge on security grounds. One such finding is "treatment for serious mental or neurological disorder."

Of course, a man can have shingles or sciatica without being in any way unstable. But the differences between psychiatry and neurology were apparently lost in the Federal shuffle. So it was probably inevitable that some innocent victim of a neurologic disorder would eventually be branded as a "security risk."

It happened to a man named Charles Christie. He had worked faithfully, and with perfect emotional stability, for Republic Aviation. Since he worked on Government contracts, he became subject to a security check. In June, 1954, Christie was suspended, charged with having apparently received "treatment for serious . . . neurological disorder."

His ailment? Neurodermatitis, contracted while serving his country in a tropical jungle. It took until November to straighten the matter out. Meanwhile, Christie survived without income and under a security shadow.

His itch is gone now—probably scared away.

—H. SHERIDAN BAKETEL, M.D.

There's always a Leader!



The Daily Log

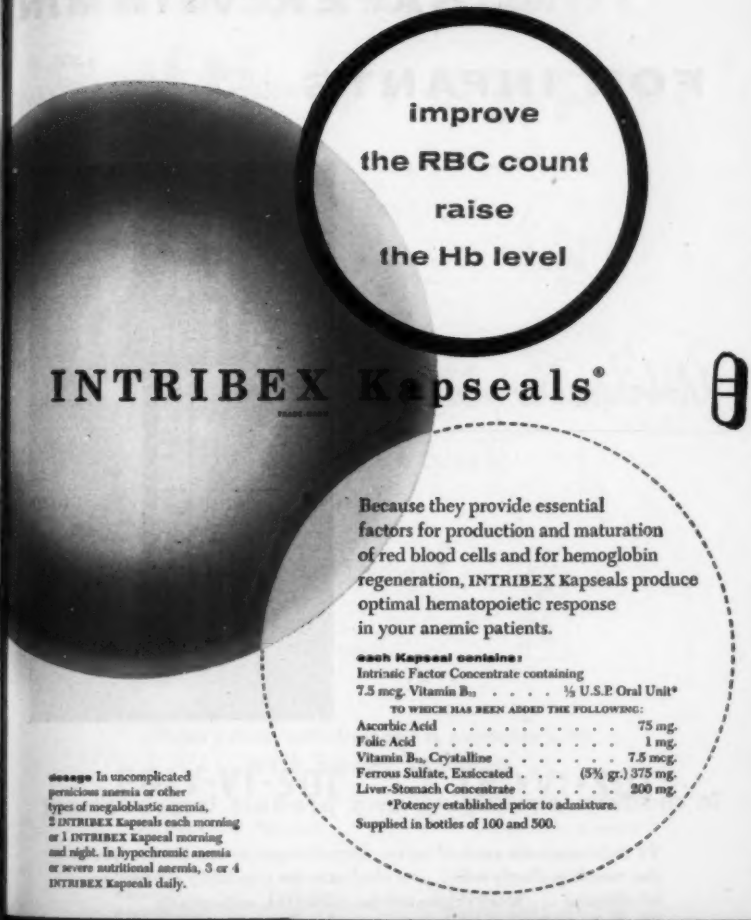
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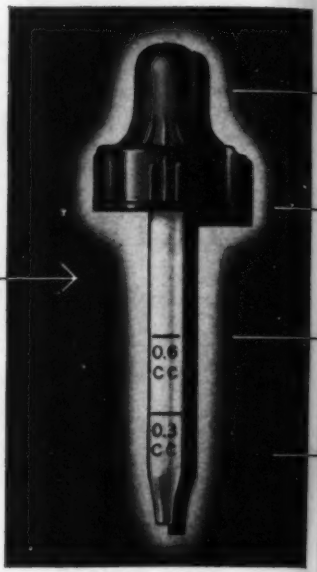

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the RBC count
raise
the Hb level
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Because they provide essential factors for production and maturation of red blood cells and for hemoglobin regeneration, INTRIBEX Kapseals produce optimal hematopoietic response in your anemic patients.
each Kapseal contains:
Intrinsic Factor Concentrate containing
7.5 mcg. Vitamin B12 . . . . . ½ U.S.P. Oral Unit*
TO WHICH HAS BEEN ADDED THE FOLLOWING:
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Supplied in bottles of 100 and 500.
dosage In uncomplicated pernicious anemia or other types of megaloblastic anemia, 2 INTRIBEX Kapseals each morning or 1 INTRIBEX Kapseal morning and night. In hypochromic anemia or severe nutritional anemia, 3 or 4 INTRIBEX Kapseals daily.
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Unbreakable plastic!



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ADMINISTRATION
'Safti-Dropper'

Won't chip or break



even if the child bites it . . . even if twisted or bent.

More convenient



dose can be given directly into the infant's mouth, the method preferred by mothers.

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correct dosage can be read easily and accurately.

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Each 0.6 cc. supplies:

Vitamin A	5000 units
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Each 0.6 cc. supplies:

Vitamin A	5000 units
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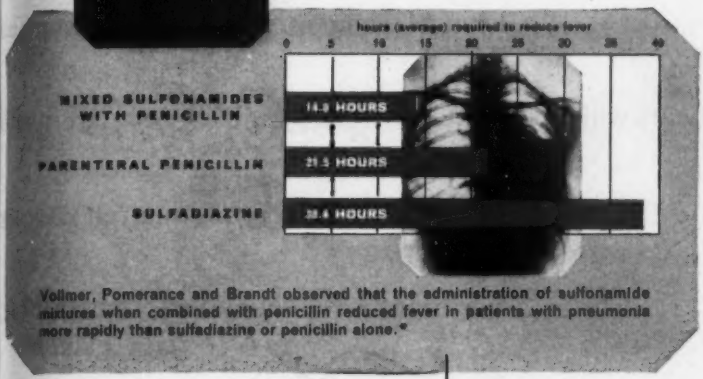
Both Poly-Vi-Sol and Tri-Vi-Sol are available in a convenient new 30 cc. size as well as in 15 and 50 cc. bottles.

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you're right in recommending
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HOT WHOLE WHEAT CEREAL
because INSTANT RALSTON
• is whole grain cereal with added wheat germ—3 times as much wheat germ as in whole wheat itself!
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10
Instant
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WHOLE WHEAT CEREAL

combined action means faster patient recovery



Vollmer, Pomerance and Brandt observed that the administration of sulfonamide mixtures when combined with penicillin reduced fever in patients with pneumonia more rapidly than sulfadiazine or penicillin alone.*

the preferred quadri-sulfa mixture...

DELTAMIDE® *w*/penicillin

combines 4 of the most useful sulfonamides with penicillin for—

a wider antibacterial spectrum

the advantages of a sulfonamide combination: faster therapeutic blood levels and better sustained; higher solubility in the urine; greatly reduced renal toxicity and lessened side-effects.

the true potentiation of action that occurs with the use of sulfonamide mixtures

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*Vollmer, H.; Pomerance, H. H., and Brandt, I. K.: New York State J. Med. 50: 2293, 1950.

Each tablet or teaspoonful of the pleasant-tasting chocolate-flavored suspension contains:

DELTAMIDE	DELTAMIDE *w*/penicillin
0.167 Gm. sulfadiazine	0.167 Gm.
0.167 Gm. sulfamerazine	0.167 Gm.
0.056 Gm. sulfamethazine	0.056 Gm.
0.111 Gm. sulfacetamide	0.111 Gm.
— penicillin G	250,000 Units

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The new antitussive . . . **CLISTIN**

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Patients will be delighted  wi

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Clistin Expectorant is non-narcotic . . . compatibl

desired.  It does not num

The combination of expectorants gives an additive effe

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Each 30 cc. (1 fl. oz.) contains:	
Clistin Maleate (*Carbinoxamine Maleate, McNeil*)	12 mg.
Ammonium Chloride	0.8 Gm. (12 gr.)
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Pints and Gallons

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or non-allergic



origin...contains

of unsurpassed therapeutic potency and safety.

Clistin Expectorant's appealing fruity flavor





however, with commonly used narcotic salts if so

the mouth or upset the stomach



yet minimizes digestive disturbances. Its special

local irritation



For coughs
that "hang on"
...try

CLISTIN®

*Carbinoxamine Maleate, McNeil

EXPECTORANT



For every woman presenting classic menopausal **hot flushes,** there is another who exhibits symptoms which are equally distressing but less clearly defined. For example, insomnia, easy fatigability, **headaches** may also be symptoms of declining ovarian function, but frequently are not so recognized because they occur long before and even years after menstruation ceases. When such is the case, the patient may be expected to **respond** to estrogen therapy. **"Premarin"** (complete equine estrogen-complex) produces not only prompt symptomatic relief but also imparts a gratifying **"sense of well-being."** It has no odor . . . imparts no odor. "Premarin"® estrogenic substances (water-soluble), also known as conjugated estrogens (equine), is supplied in tablet and liquid form.



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a 10-mg dose of Romilar

is equivalent to

a 15-mg dose of codeine

available in tablets

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*L. J. Cass *et al.*, *New England J. Med.*, 249:132, 1953; *Am. J. M. Sc.*, 227:291, 1954.

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FEE COMPLAINT

(a case history)

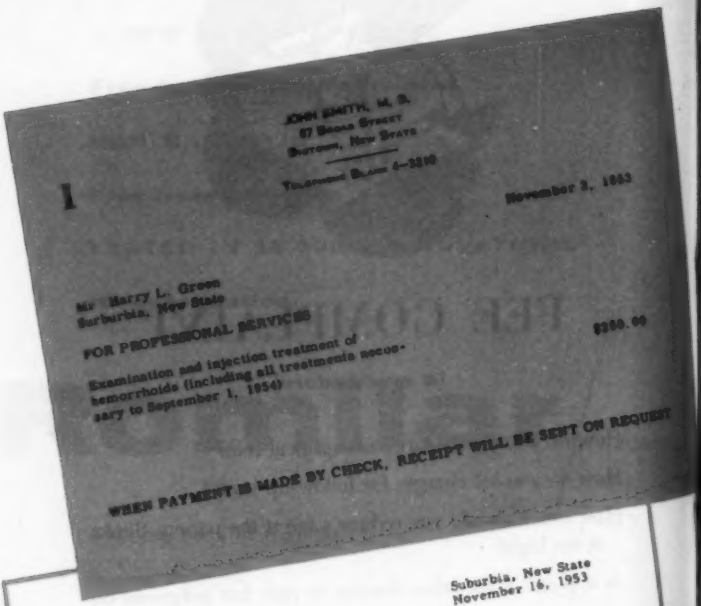
How do you justify large nonsurgical fees?

How do you set charges for follow-up visits?

How much should you reduce a fee if the patient thinks it too high?

Is it possible for other doctors to pass fair judgment on your own special fees?

• The correspondence printed on the following pages doesn't answer these questions; but it raises them and sheds valuable light on the underlying problem. Except for necessary disguising of names and some other details, the letters are printed exactly as they were originally written. Read them—and then consider how *you* would have handled the problems these physicians faced. Would you have done differently? If so, how?



1

JOHN SMITH, M. D.
87 Beaux Street
Bayport, New State

Telephone Bayport 4-3210

November 2, 1953

Mr. Harry L. Green
Surburbia, New State

FOR PROFESSIONAL SERVICES

Examination and injection treatment of hemorrhoids (including all treatments necessary to September 1, 1954) $250.00

WHEN PAYMENT IS MADE BY CHECK, RECEIPT WILL BE SENT ON REQUEST

2

Suburbia, New State
November 16, 1953

Dear Dr. Smith:

I received your bill some time ago and think there must be some mistake about it, as it seems excessive to me. I think I was in your office about ten times and that makes the visits $25 each. About two years ago Mrs. Green was quite ill and a heart specialist came to Suburbia on a Saturday night and spent over an hour here; and his bill was $50. My visits to your office only took a few minutes. I do not understand the notation "including all treatments necessary to September 1, 1954" at the bottom of your bill. I prefer to be charged for any services to date.

Awaiting your advice on the matter, I am

Very truly yours,

Harry L. Green

Harry L. Green

3

JOHN SMITH, M. D.
87 Broad Street
Bistown, New State

Telephone Blank 4–3210

November 18, 1953

Mr. Harry L. Green
Surburbia, New State

Dear Mr. Green:

I am very sorry that you think I have overcharged you for the treatment of your hemorrhoids.

In the injection treatment of hemorrhoids I cannot base my fee upon the number of treatments, but feel that the course of treatments is equivalent to an operation and that I am entitled to charge for the treatments an amount comparable, if not equal to, the amount I would charge for an operation and subsequent dressings. In addition, I like to keep my patients under observation for a year, and that is the reason I put in the notation that you have quoted, when I sent you a statement. It does not necessarily mean that you will need treatments for a year; but if they are needed, I shall be very glad to give you any advice or treatment during that time. I might add that the injection method of treating hemorrhoids properly is a special field and should be done skillfully to attain results without pain.

However, if you feel I have overcharged you, I shall be glad to deduct 20% from my bill if you want to send a check before December 1.

Trusting this explanation is satisfactory to you and that you have had relief as a result of my ministrations, I am

Very sincerely yours,

John Smith

JS/rz

John Smith, M. D

[MORE ▶

4

Suburbia, New State
November 24, 1953

Dear Dr. Smith:

Receipt is acknowledged of your letter of November 18th. In basing your charges to me for services rendered, it is my opinion that you arrived at your figures on two untenable premises:

1. That you have charged for treatments an amount comparable to an operation and subsequent dressings. It was not an operation, and the reason a patient goes to a doctor is to correct a condition which may lead to an operation, whether such a doctor is a specialist in his line or a general practitioner. Your treatments to me were of short duration and ten in number according to my calculations, and I do not see how they can be considered other than office visits.

2. Your willingness to give me further treatments without charge until September 1, 1954. I believe I should be charged for services rendered to date and would be willing to pay a reasonable fee for any subsequent treatments needed. If I want the insurance involved in your method of charging, I would cover it by an insurance policy. Furthermore, as I am to be in Florida this Fall and for the Winter, your treatments would not be available to me--and likewise in case of your disability or decease.

Under the circumstances, I must decline to pay the amount of your bill that you now suggest, i.e. $200 or anywhere near that amount.

As we are apparently at considerable variance on the question of your bill, I am willing to submit the matter to the County Medical Association--and to abide by their decision as to what constitutes a fair charge--but of course would desire to present to them in writing or otherwise my views on the matter.

Awaiting your further advices, I am

Very truly yours,

Harry L. Green

Harry L. Green

5

JOHN SMITH, M. D.
87 Broad Street
Bigtown, New State

Telephone Blank 4–3210

Mr. Harry L. Green
Surburbia, New State

November 28, 1953

Dear Mr Green:

According to my records I have not seen you since October 15th.

At this time I would like to see you to see the result of the treatments and determine whether you need any more treatments before you leave for Florida. I am consequently making an appointment for you at 2:30 p. m. Tuesday, December 1. Trusting this will be convenient for you, I am

Sincerely yours,

JS/rz

John Smith, M. D.

6

Suburbia, New State
November 28, 1953

Dear Dr. Smith:

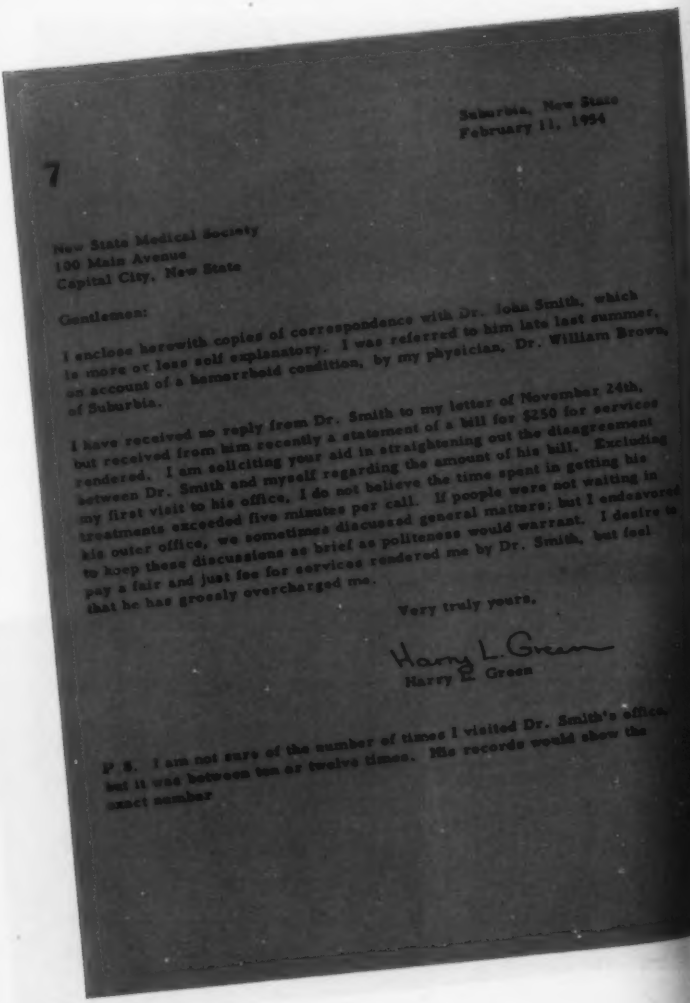
Receipt is acknowledged of your letter of November 26th. I have been out of town most of this past week and will be tied up with various things all next week, so will be unable to accept the appointment for Tuesday, December 1st, at 2:30 p. m. I wrote you a couple of days ago; and no doubt you have received my letter by this time.

Very truly yours,

Harry L. Green

Harry L. Green

[MORE ▶



Suburbia, New State
February 11, 1954

7

New State Medical Society
100 Main Avenue
Capital City, New State

Gentlemen:

I enclose herewith copies of correspondence with Dr. John Smith, which is more or less self explanatory. I was referred to him late last summer, on account of a hemorrhoid condition, by my physician, Dr. William Brown, of Suburbia.

I have received no reply from Dr. Smith to my letter of November 24th, but received from him recently a statement of a bill for $250 for services rendered. I am soliciting your aid in straightening out the disagreement between Dr. Smith and myself regarding the amount of his bill. Excluding my first visit to his office, I do not believe the time spent in getting his treatments exceeded five minutes per call. If people were not waiting in his outer office, we sometimes discussed general matters; but I endeavored to keep these discussions as brief as politeness would warrant. I desire to pay a fair and just fee for services rendered me by Dr. Smith, but feel that he has grossly overcharged me.

Very truly yours,

Harry L. Green

Harry L. Green

P. S. I am not sure of the number of times I visited Dr. Smith's office, but it was between ten or twelve times. His records would show the exact number

8

THE NEW STATE MEDICAL SOCIETY
100 Main Avenue
Capital City, New State

February 14, 1954

Mr. Harry L. Green
Suburbia, New State

My dear Mr. Green:

This will acknowledge your letter of February 11 and the attached material making complaint concerning an alleged overcharge for professional services on the part of Dr John Smith of Bigtown. There is a mechanism for handling complaints of this kind, and primary review originates with the Board of Censors of the county medical association of the county in which the physician resides. If for any reason the complaint cannot be satisfied by hearing and adjustment at the county level, it is then referred to the Committee on Professional Relations of the State Medical Society. In order that this procedure may be carried out, I am forwarding your correspondence and a copy of this letter to the appropriate committee of the Bigtown County Medical Association. You will doubtless receive further correspondence from the committee chairman

Sincerely yours,

Charles Jones

CJ/e
cc/BCMA

Charles Jones, M. D.
Secretary

9

Suburbia, New State
September 30, 1954

Bigtown County Medical Association
350 Broad Street
Bigtown, New State

Gentlemen:

On February 14th--over seven months ago--Dr. Charles Jones of the State Medical Society wrote me that he was forwarding to you copies of letters that bear upon my fee complaint against Dr. John Smith of 87 Broad Street, Bigtown. Since that date I have had no further word on the case, and only yesterday I received another bill for $250 from Dr. Smith. Would you please inform me of the present status of my complaint? I'd like to get this matter settled.

Very truly yours,

Harry L. Green

Harry L. Green

[MORE ▶

XUM

10

A. B. ROE, M. D.
Marshall Lane
Crossroads, New State

October 11, 1954

Mr. Harry L. Green
Suburbia, New State

Dear Sir:

I today received a letter from the Clerk of the Bigtown County Medical Association together with your letter dated September 30, 1954, in which you complain that you have just received another bill from Dr Smith for $250 and would like to get the matter settled.

At the meeting of the Bigtown County Medical Association held on May 21, 1954, it was voted, after hearing a report from the Chairman of the Board of Censors, that in view of the fees charged by other physicians for similar services, the Board of Governors upholds the fairness of the fees charged Mr. Green by Dr. Smith for his services. It was also voted that you be informed of this vote.

I feel that not only the Board of Censors but the Board of Governors of the Bigtown County Medical Association have considered your complaint very carefully; and it is the opinion of these boards that Dr. Smith's fees were not exorbitant.

Yours sincerely,

A B Roe

A. B. Roe, M.D.
Chairman, Board of Censors
Bigtown County Medical Association

ARB/lg

11

Suburbia, New State
October 13, 1954

Dr. Charles Jones, Secretary
New State Medical Society
180 Main Avenue
Capital City, New State

My dear Dr. Jones:

Please refer to your letter to me under date of February 14, 1954, concerning my complaint of overcharge of Dr. John Smith of Bigtown for services rendered me.

On September 30th I wrote the Bigtown County Medical Association inquiring of the status of my complaint and received a letter from Dr. A. B. Roe of Crossroads under date of October 11th, stating that at a meeting of the Association held on May 21, 1954, the fairness of Dr. Smith's fees was upheld by said association. I do not understand why I was not notified of this action until after my letter of inquiry on September 30th.

I am not satisfied with the decision of the County Medical Association, and in accordance with information set forth in your letter to me under date of February 14, 1954, I now desire the matter referred to the Committee on Professional Relations of the State Medical Society. Would you kindly inform me of the procedure involved? I desire to present my case either in person or through my attorney. Awaiting your reply, I am

Very truly yours,

Harry L Green

Harry L. Green

12

THE NEW STATE MEDICAL SOCIETY
100 Main Avenue
Capital City, New State

November 30, 1954

Mr. Harry L. Green
Suburbia, New State

Dear Mr. Green:

The Committee on Professional Relations of the New State Medical Society met on Tuesday afternoon, November 23, for the purpose of reviewing the complaint brought against Dr. John Smith of Bigtown by Harry L. Green of Suburbia, alleging overcharge for a course of injection treatment for hemorrhoids.

There were present: Dr. Head, Chairman; and Drs. White, Gray, Smythe, and Doe. Absent: Dr. Black.

Mr. Green was present, accompanied by his attorney; and he presented the details of his complaint against Dr. Smith, stating that the treatment consisted of ten or eleven visits to Dr. Smith's office, each visit occupying the physician's time for about five minutes and that he had received a bill from Dr. Smith for $250. It was this fact that he was protesting. Mr. Green also stated that he brought this complaint to the Board of Censors of the Bigtown County Medical Association and that Board had exonerated Dr. Smith. But, although a decision was reached in the matter by the Board of Censors on May 21, he had not been informed of this action until October 11, 1954, after he had written to the Association asking for a report on the matter. He pointed out also that he had not been asked to appear before the Bigtown County Board of Censors to present the details of his complaint.

Dr. Smith was next heard and presented his side of the case. He was in agreement with the statement made by Mr. Green as to the number of treatments given him and stated that in his opinion the charge was not exorbitant or unusual for the services rendered.

The Committee in executive session considered the statements made by the complainant and defendant physician and voted:

1. That in its opinion the charges made by Dr. Smith for the services to Mr. Green were excessive and that a fair charge would have been $25 for the first visit and $10 each for subsequent visits, a total of $125.

2. That whenever complaints of this nature are heard by the Board of Censors of a County Medical Association, the complainant should be invited to appear in person.

3. That the delay on the part of the Bigtown County Medical Association in notifying the complainant, Mr. Green, of the action of its Board of Censors was unfortunate.

4. That copies of these findings be sent to Dr. Smith, Mr. Green, the President and Clerk of the Bigtown County Medical Association.

C. Harold Head

C. Harold Head, M. D., Chairman
Committee on Professional Relations

END

XUM

They Take Their Own Medicine

A periodic physical exam is a must for staff members of this hospital. So all of them are as healthy as their patients—well, nearly

By Peter Jaeger

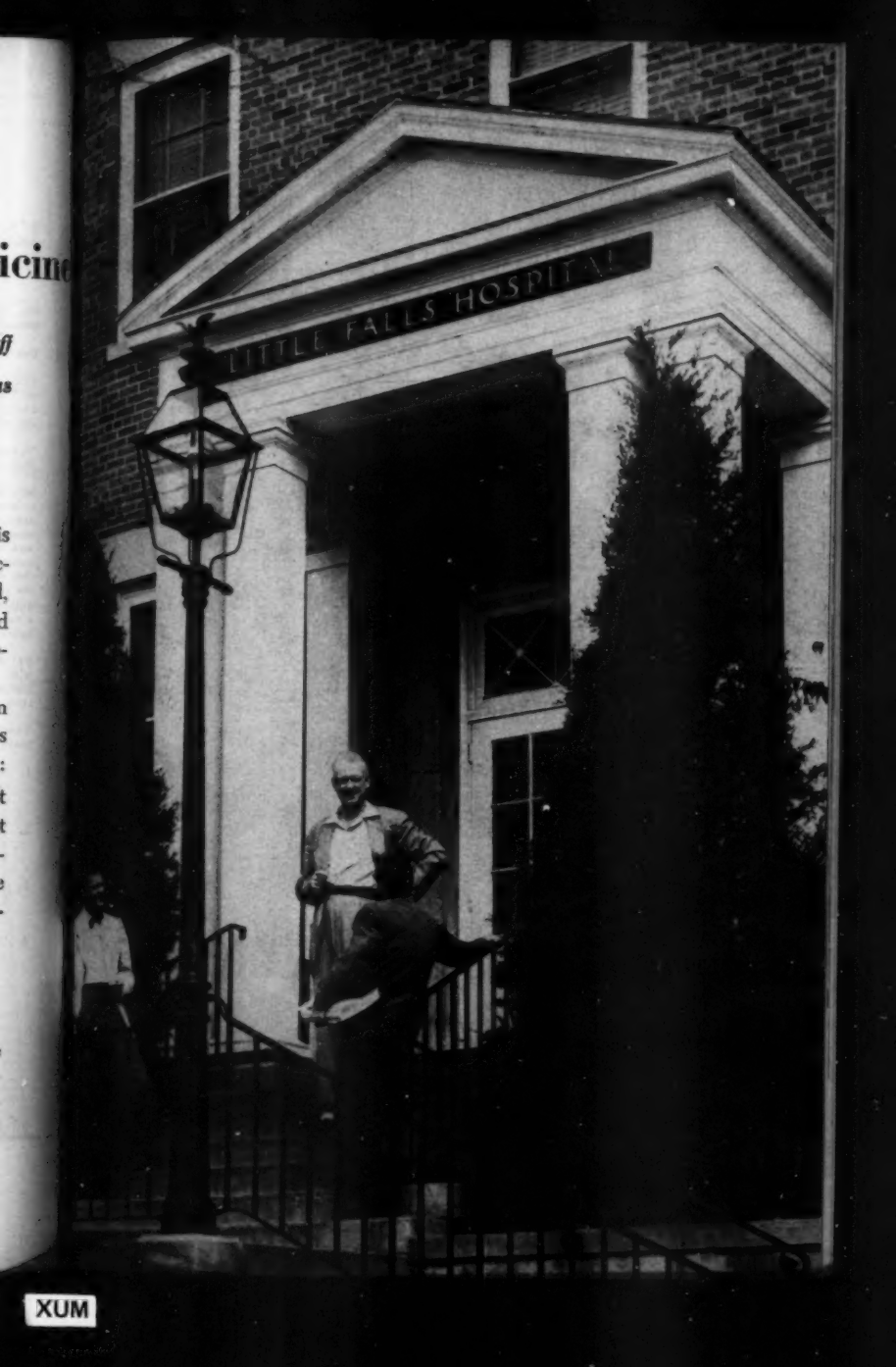
● In the spring of 1953, Dr. Harry D. Vickers told his colleagues at the Little Falls (N.Y.) Hospital about a lecture he'd just heard on cancer detection. "It was entitled, 'Do Doctors Take Their Own Medicine?' " he said, "and it set me thinking: Maybe *we* ought to do a little introspective thinking along that line."

In a receptive mood, another staff member, Dr. John D. White, wondered out loud how many of his colleagues had had recent physical check-ups. He soon found out:

Of the twenty-two-man staff, only six could report having undergone complete physicals within the past year. Of those six, one was an emigre, who had been required to check the state of his health before entering the U.S.; one had taken a physical as a prerequisite to re-

ANNUAL CHECK-UPS have now become the accepted rule for all twenty-two staff doctors of this hospital, which is located in upper New York State. The four-story, eighty-bed institution serves an area with a population of 20,000. ▶

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INTROSPECTIVE ATTITUDE was suggested to the medical staff of Little Falls Hospital by Dr. Harry D. Vickers, who recommended that they take a good look at the state of their own health.



STETHOSCOPIC EXAMINATION is made by Dr. John E. Kiley of Albany Medical College, who conducts over-all program. Doctor-turned-patient is John D. White, whose leading question helped get ball rolling a year ago.

newing his pilot's license; and the other four had been under treatment for minor ailments.

Of the remaining sixteen staff members, two dated their last check-ups back in 1945, three in 1946, ten in the years between '46 and '51. And one admitted he couldn't remember when he'd last been looked over.

This made it clear to Dr. George A. Burgin, then president of the staff, that, as he now puts it, "We doctors

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INTENSIVE INTERVIEWS are a highlight of physical exams. Here Dr. Kiley, in white coat, discusses personal-history record with Dr. Robert C. Ashley.

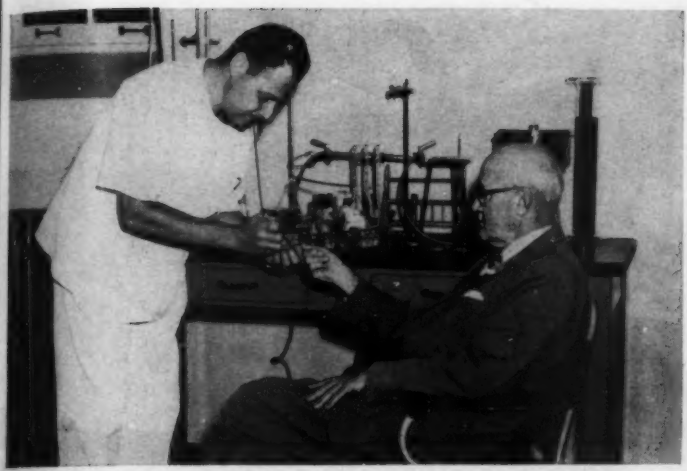
were neglecting ourselves shamefully." So he converted Dr. Vickers' suggestion for "*introspection*" into a drive for *inspection*. He carried on—and soon won—an active campaign to make annual physical exams a "must" for every man on the Little Falls Hospital staff.

They Like It

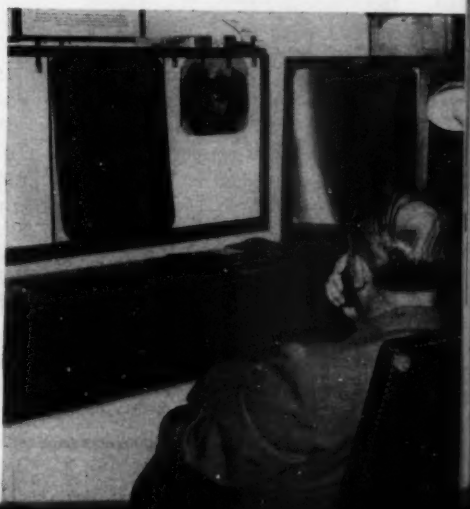
In September of that year, the rule went into operation. The physicals were repeated in the fall of 1954. There seems little danger of the program's lapsing. "Every last one of us thinks it's a fine idea," says Dr. Bernard J. Burke, current staff president.

It Costs Little

To conduct the examinations, the doctors sensibly brought in an outsider—Dr. John E. Kiley, of the teaching staff of near-by Albany Medical College; and it was agreed that each staff member would pay him a $10 fee. Two staff men—Dr. Joseph W. Conrad, cardiologist, and Dr. William A. Jarrett, roentgenologist—contributed their services for

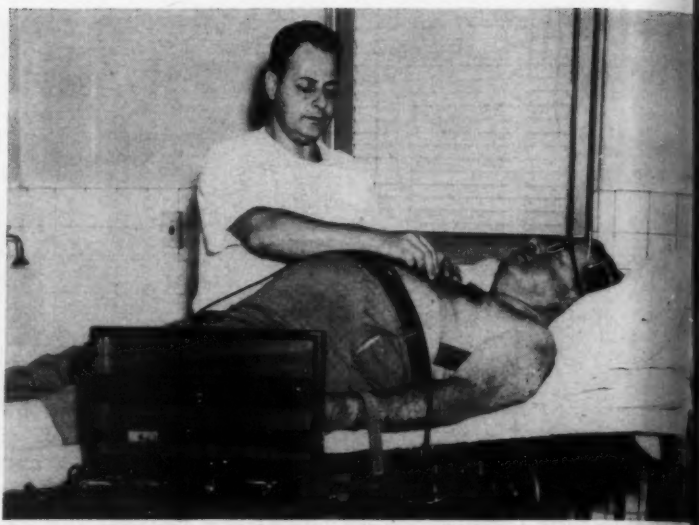


BLOOD COUNT for Dr. Jere J. McEvilly is in prospect as technician Floyd Patton pricks his finger. Laboratory tests also include routine urinalysis.



CHEST X-RAY interpretations are made gratis by Dr. William A. Jarrett, staff roentgenologist. During all check-ups to date, he has uncovered nothing worse than two cases of chronic bronchitis.

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ELECTROCARDIOGRAM readings are contributed to the project by staff cardiologist Dr. Joseph W. Conrad (not shown). Here another staff member, Dr. Paul W. Adler, is being readied by technician Patton.

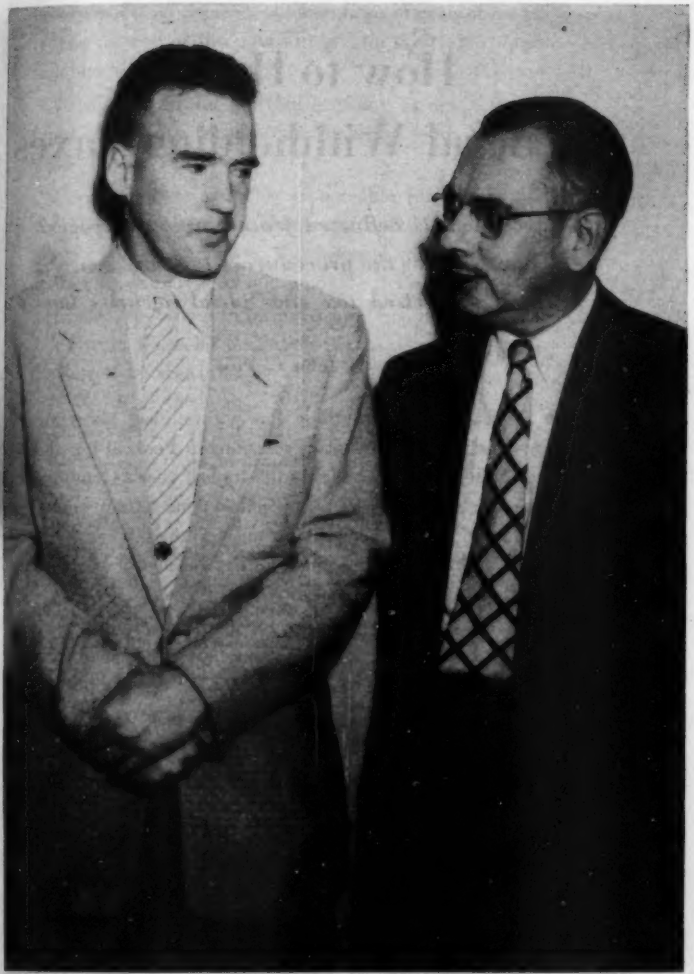
the electrocardiogram and X-ray interpretations. And the hospital's board of directors agreed to a $5 laboratory fee for each doctor, the rest of the lab expense to be absorbed by the hospital. Total cost per doctor: $15.

Kiley Follows Through

After completing the exams in 1953, Dr. Kiley set up confidential medical files on the staff. He also wrote each member a personal letter advising him of the current state of his health. And he recommended treatment in cases where it was indicated.

Actually, he had found only two unsuspected conditions among his twenty-two patients—one of hypertension, one of kidney malfunction. "We've got a couple of cases of chronic bronchitis, too," he says. "Both men are heavy smokers; so I told them, back in 1953, to cut down. Naturally, they were puffing away as heavily as ever when I saw them again a year later."

XUM



STAFF PRESIDENT of Little Falls Hospital, Dr. Bernard J. Burke, and his predecessor, Dr. George A. Burgin, endorse the physical examination plan and have given it their strong support since its inception two years ago. END

How to Handle Federal Withholding Taxes

How much is deducted from employes' wages? When? What's the procedure? Here are answers, based on revised tax and Social Security laws

By John C. Post

● Several new regulations for withholding taxes are now in effect, as a result of revisions in Federal tax and Social Security laws put through by last year's Congress. Some doctors who have never before done so may henceforth have to withhold taxes from employes' wages; and many other physicians may find it necessary to make broad changes in their withholding routine.

So this seems a good time for a general review of all such procedures. Let's take a quick look, then, at (1) the over-all withholding requirements of the income tax and Social Security laws; (2) the new regulations; and (3) the various forms most employers must be familiar with.

To begin with the law itself: The Government has saddled the busy physician with the following triple-threat burden (in addition to his other personal tax worries):

¶ He must make Solomon-like decisions as to which of his assistants are bona fide employes and which of them are independent contractors.

¶ He must calculate, withhold, and deposit the income

MR. POST *is president of Professional Business Management, Inc., Washington, D.C.*

taxes and Social Security contributions of each of his employes, as well as the payroll taxes for which he himself is liable.

¶ He must fill out and file as many as nine different types of employe forms—some monthly, some quarterly, some annually.

The law holds a doctor responsible for withholding and filing only when he meets the definition of an employer. For tax purposes, the Internal Revenue Service defines an employer as one who:

1. Has the power to hire and fire;
2. Bears financial and professional responsibility for the acts of his staff;
3. Specifies the way in which work should be done, as well as its end result; and
4. Furnishes the equipment and space used by the staff.

In some cases, the physician won't have the above responsibilities toward the individual who works for him. The assistant will be, in other words, an "independent contractor." Let's define this term.

An independent contractor—for whom you withhold *neither* Social Security nor income taxes—is one who:

1. Performs his work without the supervision of the person hiring him;
2. Supplies his own tools; and
3. Works at his own convenience (though he may agree to complete the job by a definite date).

By the above definitions, the doctor's secretary, his nurse, and his full-time technician are obviously employes —and taxes must be withheld for them. But his auditor and the laboratory technician who works for a job-fee are independent contractors. (Remember, by the way, that the doctor must also withhold for any help hired to fill in during vacation periods of regular employes; such

temporary assistants are clearly *not* independent contractors.)

All too often, naturally, there are borderline cases of staffers or workers who may fall into either class.

Take, for example, the physician who has engaged an assistant to help with his practice. The junior man, a licensed M.D., is qualified to treat patients on his own. But this is not a partnership, for the assistant is paid a salary.

You might think that the senior physician has no responsibility to withhold; for, after all, doctors usually pay their own income taxes direct, and Congress specifically exempted doctors from compulsory Social Security. But such exemptions apply only to "independent" professionals. The fact that the senior physician meets the four criteria of an employer means that he has to withhold both income and Social Security taxes for the other M.D.

On the other hand, suppose one

Whose Federal Taxes Must You Withhold?

Type of Help	Income Taxes	Social Security Taxes
Regular employe*	Yes	Yes
"Casual" office worker*	No	Yes
"Casual" home worker*	No	Yes, if you pay him $50 or more in a calendar quarter.
Domestic servant	No	Yes, if you pay him $50 or more in a calendar quarter.
Agricultural worker	No	Yes, if you pay him $100 or more in one year.
Independent contractor*	No	No

*As defined, for tax purposes, in accompanying article. (Note, however, that you *don't* withhold Social Security taxes from the wages of a parent, wife, or minor child, even if such a person is a regular employe.)

doctor calls on another to fill in during a vacation and pays him a fixed percentage of the fees received from patients. Here, the assisting physician is not an employe, since he is solely responsible for his own actions and may even use his own equipment. (Incidentally, if you arrange for such help and pay the other man $600 or more in a calendar year, you must file an explanation of the arrangement on Form 1099.)

The Internal Revenue Service recently ruled that such a "fill-in" doctor was not an employe, even though he used the office and equipment of the absent doctor in addition to his own. The substitute, said the tax men, had worked "without supervision" as to treatment or fees, and had had "no regular working hours."

How About Relatives?

Paradoxically, if a doctor employs his father, mother, wife, or child under 21, he must skip the Social Security withholding—even when the employer-employe relationship fits all the criteria. (Apparently, it's feared that professional men would go through the motion of hiring parents, wives, or minor children, just to obtain for them the benefits of Social Security.)

Remember, though, that the physician must still withhold *income taxes* for any such employes.

So much, then, for the general requirements of the law. Now let's examine the new regulations. These can affect you in both your professional and your personal life. To begin with, consider those that apply in both spheres:

¶ There's a new wage limit for Social Security deductions. Previously, as soon as an employe had been paid $3,600 during any year, you stopped deducting for Social Security. Beginning in 1955, this amount has been upped to $4,200. As a result, employer and employe may each have to pay as much as $12 more annually.

¶ There's a new Form W-4 for Federal income tax purposes. (W-4 is the Federal Withholding Certificate on which each employe lists his exemptions.) Your employes should be advised to fill out the new form if:

1. They have a dependent child under 19 or a dependent child of any age who is a student, even though such child earns more than $600 during the year; or

2. They support any individual, whether a relative or not, who makes their home his principal abode for the taxable year, but who does *not* earn more than $600 during the year.

Under the new tax law, the taxpayer is entitled to an exemption in either of the above cases.

If any employe claims such new exemptions, you must adjust his withholding tax accordingly, of course. Legally, you don't have to make this change until July 1, unless he filled out the new Form W-4

before Dec. 2, 1954. But you *may* make the change immediately, if you wish.

Three changes in the Social Security law are important only for doctors who hire persons to do work not connected with their medical practices. These changes affect agricultural helpers, domestic servants, and "casual" labor.

Such workers are frequently hired under an agreement that makes them "employes" rather than "independent contractors." With any such employed help, you must now abide by the following regulations:

1. If you employ anyone for agricultural labor and pay him wages of $100 or more (in money, not goods) during the year, you must withhold 2 per cent of those wages—and match them with an equal amount of your own money—for Social Security. Such deductions are to be reported only once a year.

2. If you pay a domestic servant $50 or more during a calendar quarter, he too now gets Social Security coverage (with deductions reported quarterly). Under the old law, you didn't have to deduct for him unless he had also worked at least twenty-four days during the quarter; but this is no longer true.

3. If you hire persons for "casual" labor about your home (for example, to cut lawns or wash windows), the rule covering domestic servants applies. But remember this: If you hire such "casual" labor to work in or about your office, they're employed "in connection with your business," according to the law. Therefore, they're subject to Social Security withholding taxes on the very first dollar they earn.

Income taxes, however, are *not* to be withheld from wages paid to domestics or to agricultural or "casual" labor.

No Easy Way Out

Obviously, the doctor whose wife acts as his secretary and who employs very little domestic help has relatively few taxes to withhold. But the average M.D. with such office help as secretaries and technicians finds no easy way out. He must withhold taxes in two or three different categories—income taxes, Social Security, and (in some states) unemployment insurance—and he must file a variety of reports at a variety of times.

Some months, the volume is fairly light; but when monthly, quarterly, and annual reports coincide, they can be a prime source of irritation. A physician may have to contend with all the following forms (available by number from any Internal Revenue office):

Form W-4: Federal Withholding Certificate. This is filled out by the employe, kept on file by the doctor, and produced whenever the Government so requests. On it, the worker lists his name, address, Social Security number, and the number of his exemptions.

Form SS-5: Application for a So-

cial Security Account Number. Technically, this is no concern of the doctor's. But an employe has to have a number in order to work. If he doesn't already have one, the doctor had better tell him about it.

Form SS-4: Employer's Application for an Identification Number. A physician with even one employe must register with local Social Security or Internal Revenue offices within a week after he starts to pay wages. He must list his type of work and number of employes.

Form 941: Employer's Quarterly Federal Tax Return. By midnight of the last day of April, July, October, and January, every employing physician has to file this combined statement of total withheld income taxes and Social Security contributions. Payment must accompany the form.

Form 942: Employer's Quarterly Tax Return for Household Employes. This is used for reporting Social Security deductions, if you have only domestic employes, and no office help. Filing times are the same as those for Form 941.

Form 450: Federal Depository



"Surely you remember her from high school: She was 'Miss Biology Class of 1940.'"

Receipt. If your total withholdings (income tax and Social Security) exceed $100 in the first or second month of any quarter, you must deposit them (with Form 450) at your Federal Reserve Bank or at a Treasury-designated commercial bank by the fifteenth of the next month. Form 450, validated, will be returned. Attach it to the next Form 941 you file, together with check for your third-month withholdings.

Form W-2: Annual Withholding Statement. By midnight of Jan. 31, the physician-employer must file a separate statement for each employe, showing the employe's total earnings and the amounts withheld for his income taxes and Social Security. The employe gets two carbon copies for use on April 15.

Annual Statement

Schedule C: Annual Reconciliation Statement. In January, doctors must prepare a summary in Schedule C on the reverse side of the Form 941 used for the quarter ending Dec. 31. Schedule C must show how the quarterly withholdings (reported on 941s) add up to the annual totals shown on individual W-2s.

Form 940: Federal Unemployment Tax Return. As part of the Federal Unemployment Tax Act, employers of *eight or more individuals* must pay an annual 3 per cent tax on wages (up to $3,000 per employe), by Jan. 31. Where state unemployment insurance systems are tied in with the Federal—as they are in most states—employers can deduct payments to the states plus merit-rating credits, if any, from their tax liability.

There's still another tax form that the physician-employer must contend with: his state's unemployment tax return. Almost all states demand this—though rates, deadlines, and other requirements vary.

Advises Tax Tables

There is no way to make substantial cuts in the work of withholding. Figuring amounts to be withheld can, of course, be avoided by the use of withholding tables prepared by the Internal Revenue Service; and keeping track of the figures can be simplified by using forms especially designed for payroll records. But that's about the extent of it.

The thing you *can* do is to avoid making the chore any worse than it is. This means doing it systematically and without confusion, and sidestepping the pitfalls that can complicate the tax-collecting process if you happen to stumble into them. Here are some things to watch out for:

¶ Make sure you file on time; late filing—or failure to file at all—may subject you to as much as a 25 per cent penalty, plus interest.

¶ Treat bonuses and gifts as employe income—and withhold from them as you would from ordinary income. Value any non-monetary gifts in dollar terms and compute the withholding tax accordingly.

¶ Keep your records for at least four years, to avoid any argument with revenue agents over the accuracy of your returns.

¶ Ask your District Director for a copy of "Employer's Tax Guide." It will answer questions that cannot be touched on here. END

Those Lawsuit Blues

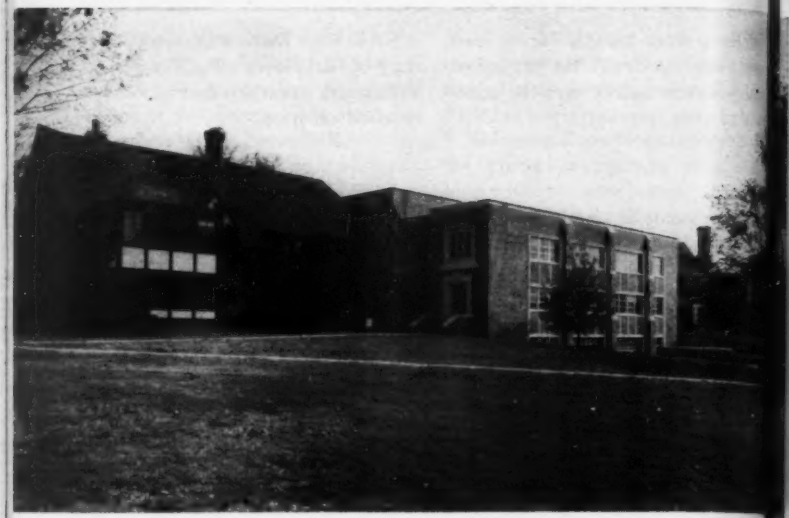
• Moaning low about malpractice rates? Then, if you remember your Gilbert and Sullivan, you can join in as Dr. Milton J. Chatton of San Jose, Calif., chants his special parody* of "Tit-Willow," from "The Mikado."

If you think consultations are "extra expense,"
Malpractice insurance is costly.
If you give verbal orders to those who are dense,
Malpractice insurance is costly.
If you leave for the country without substitute,
Or you give the impression you don't "give a hoot,"
I'll tell you now, Doctor, you're in for a suit.
Malpractice insurance is costly.

If you fail to X-ray all those fractures of bones,
Malpractice insurance is costly.
If you choose to do pelvics without chaperones,
Malpractice insurance is costly.
If you criticize colleagues for work they have done,
Or call yourself the indispensable one,
I'll tell you now, Doctor, attorneys will run.
Malpractice insurance is costly.

If you shoot off your mouth when your patients confide,
Malpractice insurance is costly.
If you dare to make house calls when "pickled or pied,"
Malpractice insurance is costly.
If you cut open patients with greatest of ease,
And your only intent is collection of fees,
I'll tell you now, Doctor, start shaking your knees.
Malpractice insurance is costly.

*Courtesy of the Santa Clara County Medical Society.



The House of Menninger

By Don Cameron

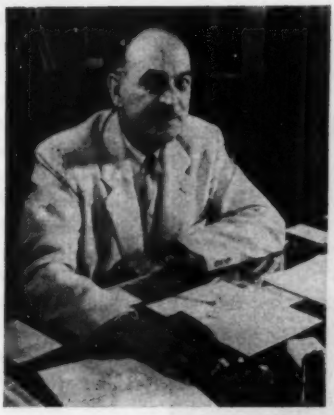
● Just what *is* the Menninger Foundation?

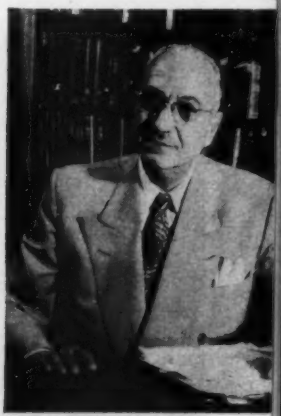
Its principals occasionally refer to it as "our little shop out here in Kansas." But even if you accept their own modest metaphor, you can't help observing that the "little shop" has made an outsized mark on several kinds of interstate commerce:

Psychiatrists trained there have gone out to practice in thirty-seven other states besides Kansas. Patients treated at the foundation during a typical recent year came from forty-one different states. And from as far away as Turkey, Thailand, and the French Congo, some 1,500 pro-

XUM

NEW SPLICED ONTO OLD: The C. F. Menninger Memorial Hospital, largest of the facilities operated directly by the foundation, now has beds for 113 patients. Despite its patchwork architecture, foundation officials say it "seems to us a very model of what a psychiatric hospital building should be." The first Menninger hospital was in a remodeled farmhouse purchased in 1925; it's used for administrative offices today. In the 1940's the Menningers turned over all their properties—land, buildings, equipment—to the nonprofit foundation bearing their name. Its assets today top $3 million.





STUDY IN CONTRASTS: William C. Menninger (left) seems quiet, gentle, almost shy—but he's the foundation's No. 1 promoter, spending two-thirds of his time on the road. His older brother Karl, restless and brilliant, stays closer to home. He's the foundation's director of professional education and also its chief of staff.

XUM

fessional visitors last year swarmed to Topeka—the city where, in the words of one native, "the human mind has become the second largest industry."

Topekans today are proud of this industry. But things were different when the Menningers started. Fired with the vision of a Mayo Clinic of psychiatry, they had to bring their vision to life on the outskirts of town: A Topeka ordinance forbade mental hospitals within the city limits.

The Menninger plant still sprawls on the city's periphery—forty acres of oddly assorted low buildings, most of them still betraying their nonprofessional origins. "Since the Menningers had little money," one of their early associates relates, "they improvised facilities as they went along. A barn, a hamburger stand, and a gas station were hitched together to become an attractive office building; a two-car garage was remodeled as the headquarters of the nursing staff; an old stable was dressed up to make a canteen and recreation hall . . . " The design of the present establishment is clearly



DISTURBED CHILDREN get special attention at the Southard School, operated as part of the foundation. There's a staff of thirty-five—and room for only sixteen in-patients. About two children in every hundred treated as out-patients qualify for this "planned experience in group living." Each child who stays in the Southard School costs the foundation more than $9,000 a year—a sum that few families are able to pay in full.



MENNINGER SCHOOL trains more psychiatric residents than any other center in the world. It also provides short-term courses for general physicians, teachers, clergymen, vocational counselors, and others interested in mental health.

the work of men who had more important things on their minds.

What were these more important things? You can get some inkling from the crackling atmosphere of intellectual and cultural activity that fills this casual shell. It springs from a dynamic mingling of various arts and sciences—all brought together with psychiatry under the broadest of roofs.

Imagine a close-knit working unit of more than 175 psychiatrists and other physicians, plus educators, social workers, psychologists, auxiliary therapists, sometimes a sociologist or an anthropologist. Picture these persons engaged in an almost continuous cerebral marathon. Visualize them seven evenings a week in animated talk at seminars, journal clubs, conferences, and other gatherings.

Now you're beginning to get the idea . . .

Sparking this conglomeration of energy, and setting its goals, are the brothers Karl and William Menninger (the "g" is almost silent, as in "singer"). On their home grounds,

XUM



DAY ROOM in new hospital addition was designed to combat "the dark and oppressive mood of the old asylum."



ACUTE CASES are referred by home-town M.D.s. But one-third of all patients come independently.



THERAPEUTIC INTERVIEW needn't be confined to the office or clinic, the Menningers and their associates feel. Here a staff psychiatrist talks informally with a patient while strolling through spacious acres of onetime Kansas farmland.

they're always "Dr. Karl" and "Dr. Will." With their father, the late "Dr. C. F."—who served as board chairman and conducted therapeutic classes into his ninety-second year—they founded and built up what is undoubtedly the world's largest training center for psychiatrists.

Dr. Karl, at 61, is the senior partner in this extraordinary brother act. He's a savant of the old school, with temperament to match; and it's anybody's guess whether tomorrow morning he'll be serene or stormy.

Most of the time, though, he's in an expansive mood. A floor-pacer who punctuates his verbal Niagara with waves of a cigarette in a long holder, he talks about everything

XUM



GROUP DECISIONS affect the treatment of almost every case seen at the Menninger Foundation. Here the subject is a disturbed child. The conferees include not only psychiatrists, but also a neurologist, a nurse, a social worker.

from politics to pedagogy to music. In high gear, he coasts authoritatively from one topic to the next. He sometimes irritates. He never bores.

His brother Will, now 55, was once dubbed by Time magazine as "psychiatry's U.S. sales manager." Dr. Will can beam at you as if utterly fascinated, then pass on with such finesse that, instead of feeling brushed off, you're convinced you've just met a wonderful fellow. And you have.

If you're about to hear Dr. Will make a speech, you can be sure he'll try to sell you either on a professional idea or on making a contribution to the foundation. So you brace yourself for resistance. No matter. Once he begins talking, you're sold.

Towering behind the brothers, the Menninger Foundation binds half a dozen operating units into one great treatment center. These units include the C. F. Menninger Memorial Hospital, the Menninger Clinic (for out-patients), and the Southard School (for children).

In addition, the foundation is responsible for the psychiatric teaching programs in almost a dozen other near-by institutions. These include the V.A.'s Winter Hospital, four Kansas state hospitals, and the Topeka Institute for Psychoanalysis. None of these institutions is administered by the foundation; but all are affiliated with the Menninger School of Psychiatry.

Heading the Menninger Foundation is an eighty-one-person Board of Governors, studded with such names as Marshall Field, Alf Landon, Floyd Odlum, Senator Frank Carlson, Mrs. Lillian Gilbreth, Father Vincent Flynn, and Dr. Paul Hawley. At the base is a contributing membership of 3,000 persons and corporations.

Among the ninety-one corporation members are the Joseph Schlitz Brewing Company, the Reader's Digest Foundation, the Doughnut Corporation of America. Among the individual members: Bob Hope, Faith Baldwin, and Francis Cardinal Spellman—plus hundreds of more modest citizens and hundreds of doctors.

They contribute sums ranging from $10 a year up to several thousand. For, like many another non-



FUTURE PSYCHIATRISTS take tough written exams at the Menninger School. This old-fashioned custom, long considered inappropriate in graduate education, was recently re-introduced as a check on teachers as well as a spur to students.

profit, quasi-public enterprise, the Menninger Foundation always needs money. Its professional services earn about $1.6 million annually—not quite enough to meet the rather conservative payroll, and some $700,000 short of total expenses. To pick up the tab, it has to depend on grants, tuition fees, and contributions.

Patients First

The Menninger Foundation is, first of all, a treatment center. Treatment—not of psychiatric disorders, but, as the Menningers put it, of human beings suffering from psychiatric disorders—comes ahead of education and research. "People are the most important thing about the Menninger Foundation," says Dr. Karl; and he goes on to prove it with this vivid cross-section of a typical day's arrivals:

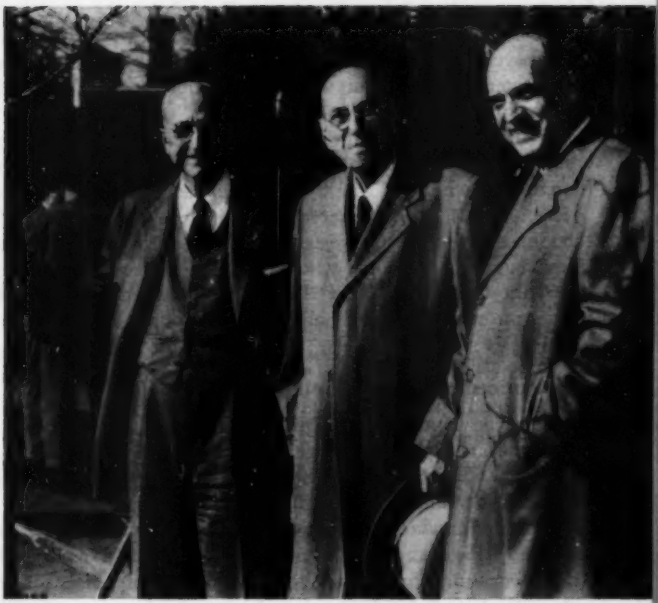
"A mother and father bring their brilliant son who has just gotten a master's degree but has suddenly turned queer: He will not speak and apparently doesn't know their names. A man brings his wife: They had prayed for a baby for nine years and at last one had come; but, ever since, the mother has been depressed and wants to kill herself. A manufacturing company official brings an executive vice president who . . . doesn't think he can work any more; he doesn't believe they want him any more (although they insist they do); he sits at his desk and drinks himself into a stupor. A woman . . . whose father died of cancer last ye has been unable to think of anythi but cancer; [she] spends ho washing her hands for fear germs . . ."

The basic therapy in every Me ninger program is rooted in psych analytic theory. But only one pa tient in ten actually undergoes an lysis, and all methods are used a indicated. In a typical year, st members give about 500 electr shock and 1,000 insulin treatmen and they do a varying number o other somatic procedures. There ar two neuro-surgeons and two clinic neurologists on the foundation staf

The major in-patient unit is th C. F. Menninger Memorial Hosp tal. Since its operating cost is $3 per patient per day, fees are neces sarily high—$1,150 a month and up This doesn't include the cost of shoc treatment or psychotherapy.

"It is not yet possible," says th foundation's latest report, "to admi patients to the hospital at less than cost." This is not to the Menningers liking, of course; and funds are cu rently being sought for thirty en dowed beds. Meanwhile, the typica patient discharged from the hosp tal during the year (after a stay o some fifty days) takes with him a bill totaling perhaps $2,000. Ab about one-third of the hospitalize patients (with a median stay of 20 days) still remain in the hospital a the end of the calendar year during which they entered. That mean their individual indebtedness up

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FOUNDATION'S FOUNDER, the late Dr. Charles Fredrick Menninger, is shown flanked by his sons. He got the group idea from a visit to the Mayo Clinic in 1908. But Karl (left) was 14 at the time, and Will was only 8; so the senior Menninger had to wait. In 1923 they began practice together; the combination lasted thirty years.

proaches $8,000, on the average.

But no one can say that these hospitalized patients don't get extraordinary services for the money. Psychiatrists generally agree that the larger the personnel of a mental hospital, the better the patient's chance of being helped. Taking the number of patients per staff employe as an index, here's how the C. F. Menninger Memorial Hospital compares with the nation's median state hospital in this respect:

	Menninger Hospital	Median State Hospital
Patients per psychiatrist	6	225
Patients per attendant	1½	9
Patients per R.N.	3	150
Patients per social worker	10	600
Patients per psychologist	62	1,500

This tabulation isn't completely

XUM

fair to state hospitals, of course. Whereas Menninger patients have acute psychoses or psychoneuroses, the greater proportion of those in state hospitals are senile or chronically schizophrenic. And chronic cases generally get less attention than do the acutely ill.

Even with this reservation, though, the figures are revealing. They suggest that people who can afford the C. F. Menninger Hospital get an extremely personal kind of care.

Economical Innovation

The same kind of care, but at lower rates, is supplied through the Menninger Clinic to some 1,000 outpatients a year, and also through the Menninger Foundation Day Hospital—one of the first in the country. This "economical innovation" permits patients to get daily treatment and take part in therapeutic activities, but spend the night at their homes or hotels. Last year its average daily patient load was thirty-five.

Outside their main hospital, the Menningers provide a growing number of below-cost services. Says their latest report: "Of the 2,197 patients—adults and children—who received psychiatric and neurological services at the foundation last year, 27 per cent were charged less for these services than it cost the foundation to provide them." This percentage is by no means as high as the Menningers would like. "The foundation does not yet have sufficient funds to provide an important volume of free clinical service," they point out. "This is a goal for the future."

Counting everyone from cooks to phone operators, from electricians to barbers, the foundation has about 400 employes. The total staff of all the Menninger-related units includes seventy-five psychiatrists, 100 residents in psychiatry, twenty-five other M.D.s, forty-five social workers, forty psychologists, forty-five students of psychology and social work, and a mixed group of auxiliary therapists and administrators.

The average age of the staff psychiatrists, incidentally, is only 39. The majority come from the East. But, as you'd expect, most of them got their psychiatric training in Kansas.

No Hermits Here

Taken as a group, they're a far different breed from the old-time "alienists" who led a hermit-like existence behind the forbidding walls of state hospitals. Menninger men are often seen around town in sports coats or tweed suits. Most have strong outside interests, ranging from classical music to collecting psychiatric cartoons.

They also work hard. You might think that the well-divided clinical load would mean a leisurely pace; but teaching and research make the difference. Their [MORE ON 249]

XUM

'Age-Analyzing' Accounts Boosts Collections

The bills your patients haven't paid become less collectible every day. But you can catch those aging debts by regularly checking your books. This article suggests a painless system

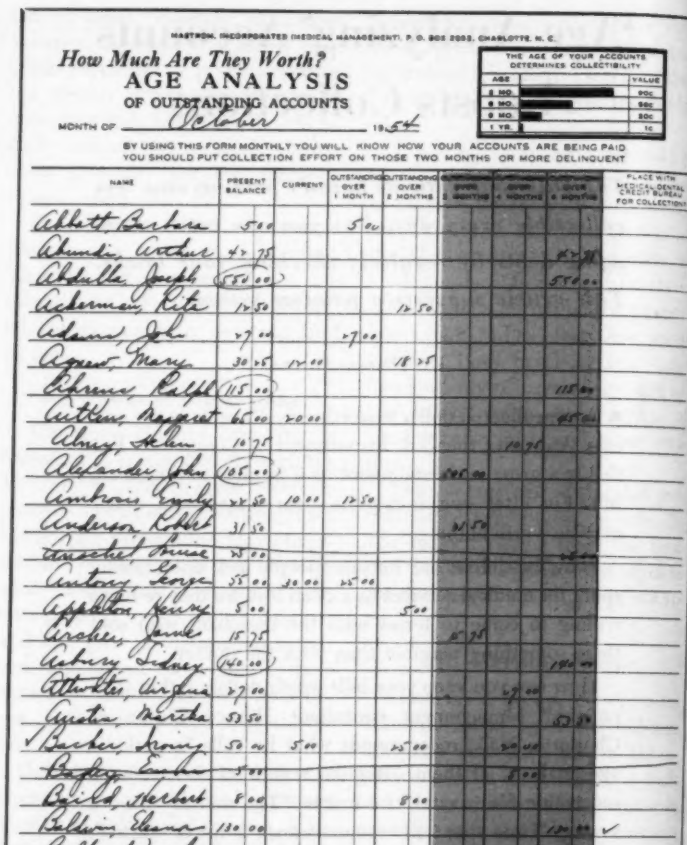
By Thomas Owens

● An uncollected dollar is worth only 45 cents at the end of a year, says the U.S. Department of Commerce. But this is a gross understatement as it applies to a medical bill. For after twelve months, *your* uncollected dollar may be worth nothing.

Why the difference? Because people look upon money spent for medical services as a dead loss. So they're more willing to come to terms with the merchant who sold them something tangible than with the doctor.

How can you keep your bills worth dollars rather than pennies? Management consultant Horace Cotton of Charlotte, N.C., recommends what he calls "a periodic age analysis" of them. "Regular review of the accounts receivable file is vital," he insists. "The military have a saying, 'Time spent on reconnaissance is never wasted'; and this axiom can—and should—be applied to the collecting of fees."

Obviously, it isn't enough for the doctor or his aide just to take an occasional look at the books. To make such a "reconnaissance" pay off, it's essential to examine outstanding debts systematically. That way, something can



MASTRON, INCORPORATED MEDICAL MANAGEMENT, P. O. BOX 2083, CHARLOTTE, N. C.

How Much Are They Worth?

AGE ANALYSIS

OF OUTSTANDING ACCOUNTS

MONTH OF October 19 54

THE AGE OF YOUR ACCOUNTS DETERMINES COLLECTIBILITY

AGE	VALUE
0 MO.	90%
3 MO.	80%
9 MO.	50%
1 YR.	10

BY USING THIS FORM MONTHLY YOU WILL KNOW HOW YOUR ACCOUNTS ARE BEING PAID. YOU SHOULD PUT COLLECTION EFFORT ON THOSE TWO MONTHS OR MORE DELINQUENT

NAME	PRESENT BALANCE	CURRENT	OUTSTANDING OVER 1 MONTH	OUTSTANDING OVER 2 MONTHS	OVER 3 MONTHS	OVER 4 MONTHS	OVER 6 MONTHS	PLACE WITH MEDICAL-DENTAL CREDIT BUREAU FOR COLLECTION
Abbott, Barbara	5 00		5 00					
Abundo, Arthur	47 75						47 75	
Abdulla, Joseph	(55 00)						55 00	
Ackerman, Rita	12 50			12 50				
Adams, John	27 00		27 00					
Agnew, Mary	30 25	12 00		18 25				
Ahrens, Ralph	(115 00)						115 00	
Aitken, Margaret	65 00	20 00					45 00	
Alsup, Helen	10 75					10 75		
Alexander, John	(105 00)				105 00			
Ambrosia, Emily	22 50	10 00	12 50					
Anderson, Robert	31 50				31 50			
Crossed-out name	25 00						25 00	
Antony, Lorge	55 00	30 00	25 00					
Appleton, Henry	5 00			5 00				
Archer, Jane	15 75				15 75			
Asbury, Sidney	(140 00)						140 00	
Atherton, Virginia	27 00					27 00		
Austin, Martha	53 50						53 50	
Barber, Irving	50 00	5 00		25 00		20 00		
Bagley, Emma	5 00					5 00		
Baird, Herbert	8 00			8 00				
Baldwin, Eleanor	130 00						130 00	✓
Ballard, Marlene	75 00						75 00	
Barker, Michael	15 00		15 00					
TOTAL OR SUB-TOTAL	962 50	77 00	84 50	69 75	152 00	62 75	621 00	

PROFESSIONAL PRINTERS, DURHAM, N. C.

SPECIAL FORMS help in "age analysis." Here, circles indicate debts needing prompt attention. Check mark at left shows habitually tardy payer; check mark at right sends account to collection agent. Crossed-out debts are written off.

be done about them before they grow too old to be collectible.

There are several possible ways to make an age analysis. One good method utilizes a special printed form like the one shown in these pages. (Mr. Cotton modeled it on a similar form prepared by the National Retail Credit Association.) Here's how it's used:

Three or four times a year, the doctor's secretary lists the names of all patients who have outstanding bills, along with the total each owes. In addition, she indicates the age of every individual debt by jotting down the amount in the appropriate column; and she totals the figures for all columns. The sample form printed here might be the first page of a typical report.

Emphasizes Old Ones

Note that debts over three months old are entered in shaded columns. This overlay of color is just a device, of course. But it's a good one: It stresses the bills that have reached the dangerous age.

The briefest study of such a list will give the physician a good idea of his aide's success at keeping her collections up-to-date. Naturally, as many accounts as possible should appear in the "current" column; crowded shaded columns are an obvious danger sign.

Once the accounts have been analyzed by age, the doctor may tell his aide to take any action he sees fit. In the accompanying sample, you'll notice that certain figures have been circled. That's how some physicians mark accounts that they feel need special—and immediate—attention.

If an account looks obviously delinquent, the doctor may direct that it be handed over to a collection agency. He can do this by means of a check-mark in the right-hand column. Or, if he decides to write off the debt as uncollectible, he can tell the aide to do so by running a line through the patient's name.

Who Are Slow Payers?

The age analysis also serves another purpose: It gives you, at a glance, a fair impression of the payment habits of your patients.

Take a look at "Irving Backer," on the sample form, for instance. He owes the doctor a total of $50, which isn't excessive. But note that only $5 of this debt is current. Half the total has been due for over two months; and he has owed $20 for more than four months. Clearly, Backer is in no hurry to pay his doctor bills.

A check alongside his name now becomes a warning to the physician's secretary. When she's aware of a patient's habitual reluctance to settle up, she becomes better able to deal with him in the future.

What It Accomplishes

It takes only a few minutes to check the age-analysis sheet, once your aide has prepared it. Yet here's what you get for very little effort:

¶ You get a clear picture of who your debtors are and of the total amount of money they owe you. (The size of this sum may surprise you. Mr. Cotton cites a surgeon, in practice only four years, who needed fifty pages to list all his outstanding accounts! They totaled $44,000—of which over half was more than six months overdue.)



DAILY WHIRL starts for New York's Dr. Leona Baumgartner as she leaves her Greenwich Village home for the office.

She Has 8 Million Patients

By Albert Meisel

● When Robert F. Wagner Jr. became Mayor of New York City in January, 1954, one of his first acts was a break with tradition: He appointed a woman to the back-straining post of Commissioner of Health.

Trim, 52-year-old Dr. Leona Baumgartner wasn't over-

¶ You see, at a glance, the age of all debts; and you can set in motion the machinery for catching up on the oldest ones.

¶ You're able to identify more quickly the perennially tardy payers.

¶ By comparing the reports at three- or four-month intervals, you get a line on how effective your collection procedures really are. END

awed by the size of her new job. But she might well have been. For the New York City Health Department is a behemoth establishment.

It has a roster of some 5,000 employes and an annual budget of $18 million—more than double that of the U.N.'s World Health Organization. It operates seventy-five pre-school child health stations and twenty district health centers. And it licenses or runs scores of research laboratories—where, in one recent year alone, over 2 million tests were made for almost every known disease.

The department also keeps an eye on health conditions in the city's 40,000 run-down tenement buildings. It inspects the million-odd dairy cows that supply the city with its milk. And it makes sure that New York's 22,000 restaurants maintain proper standards of cleanliness and sanitation.

"It's a complex job," Dr. Baumgartner admits. "But I never really doubted I could do it. For in this branch of medicine, remember, I'm an old hand."

She is that. She's been with the New York City Health Department ever since 1937. Even when she started there, she had had several years' experience as a teacher and researcher—besides having earned an impressive number of degrees (a Master's in bacteriology from the University of Kansas; a Ph.D., in public health, and an M.D. from Yale).

On the job, Dr. Baumgartner fits the popular concept of the high-powered executive. Currently, she's hard at

work paving the way for a major revision in the city's sanitary code—the first such revision in forty years.

Once a week, she appears on a network TV show, where, in terms that all can understand, she talks about common problems of accident prevention and sanitation. A couple of recent topics: the contents of a well-stocked medicine cabinet; the dangers of carbon monoxide.

Off Hours

On nights when she's free, and on occasional week-ends, she enjoys puttering around her apartment. Says her husband, chemical engineer Nathaniel Elias: "My wife's a fine doctor. But she's a positively magical cook. She makes the best ten-minute meals in town."

Summers, they vacation at Martha's Vineyard, where the Health Commissioner drives a 1932 jalopy called "Duffy" and, as she puts it, mostly "lazes around." To keep in training, though, she also serves as chairman of the local garbage-disposal committee.

A measure of what Leona Baumgartner has accomplished is her winning, in 1954, of the American Public Health Association's highest honor: the Albert Lasker Award.

The award has never before gone to a city health commissioner. Says Dr. Baumgartner's citation, in part: "Throughout her career she has been a vocal advocate of better health for mothers and children, and has made her mark on many enterprises, notably on the school health services of a great metropolis. She has been well described as an advocate of 'pandemic well being.'"

In a man's world, Leona Baumgartner has indeed gone a long way.

END

Teller's Delight

● On busy afternoons in our office, I sometimes help the secretary stamp the day's checks for deposit. One such check was returned to us recently, with a cryptic note from the bank saying: "Please endorse with signature, not medical advice."

I took another look at the check. Apparently on that occasion I had picked up the wrong stamp—a drug stamp used in our office. For the words imprinted on the back of the check read: "One teaspoonful to quart of warm water for daily douche."

—REGINA GIRARD, R.N.

XUM

Health Bills Caught in Political Wringer

Only medical legislation that wins support of both the Democratic Congress and the Republican Administration is likely to squeeze through

By R. Cragin Lewis

● During the life of the Eighty-fourth Congress, now getting started in Washington, at least 10,000 legislative measures are sure to be introduced. Fully 400 of these bills will directly concern the medical profession.

Which ones are most likely to become law?

The answer depends not so much on the bills themselves (most of them still unwritten) as on the political temper of our newly divided Government. Where health legislation is concerned, "distemper" might be a better word for it. Note these symptoms:

¶ Medical measures that the Eisenhower Administration especially wants aren't likely to get through the Democrat-controlled committees of Congress. For proof, you need look no further than Democratic reactions to the President's pet project—Federal reinsurance of voluntary health plans. Senator Lister Hill (D., Ala.), new chairman of the Senate Committee on Labor and Public Welfare, calls the proposal "much ado about nothing." And Representative J. Percy Priest (D., Tenn.), new chairman of the House Committee on Interstate and Foreign Commerce, says the scheme is riddled with "major inner contradictions." [MORE▶



DOMINANT FIGURES in forthcoming health controversy are Senator Lister Hill and Mrs. Oveta Culp Hobby. Senator Hill, son of a surgeon, wants to extend voluntary health plans via broad subsidies—just as hospital facilities were extended under his Hill-Burton Act. But Secretary Hobby says such subsidies would be "a deterrent to the purchase of health insurance" by self-supporting families.

¶ Medical measures that the Democrats especially want aren't likely to get past the President's veto. His threshold of pain on Federal subsidies, for example, is a lot lower than the Congressional majority's. Speaking for the President, Mrs. Oveta Culp Hobby recently ruled out broad Federal-state grants "to subsidize nonprofit voluntary insurance coverage"—something that Senator Hill and other Democrats favor. Said Mrs. Hobby: "Such subsidies, in our view, are not consistent with the principle of self-help . . . to which the President is dedicated."

Does this mean a two-year stalemate, then, with each branch of Government batting down the other's health proposals?

They Don't Flinch

It's not quite that simple. Broad, bipartisan agreement can still push any new bill through. And neither branch of Government necessarily flinches at Federal spending for health.

This fiscal year, for example, they've already authorized $2 billion for that purpose. As Dr. Frank E. Wilson, the A.M.A.'s Washington

representative, points out, this is "one-sixth of all the money spent in any way for medical and health items in this country annually . . ."

How, then, will these forces operate during the current session of Congress? Here's what you can expect in five major fields:

Carlson's Bill

1. *Look for a big new program to extend voluntary health insurance to millions more Federal workers and their families, with Federal funds paying part of the bill.*

For years, doctors and others have been saying: "Government workers should be permitted to arrange payroll deductions for voluntary health insurance. Private business allows and encourages this; the Federal Government, with 2½ million employes, doesn't."

Now the Government seems ready to offer this privilege—plus some financial help besides. Too late for action at the last session, a bill introduced by Senator Frank Carlson (R., Kan.) shows what the legislators have in mind. It would:

¶ Authorize Federal employes to arrange payroll deductions for any "approved" type of voluntary health coverage.

¶ Authorize Federal contributions (up to $26 a year) to help each employe pay his health-plan premiums.

¶ Authorize agency heads to list "approved" health plans—and to negotiate for group coverage of their workers, if desired.

This proposal has stirred up considerable excitement among the voluntary plans. At stake is the enrollment of perhaps 5 million new members (counting dependents). The Blue Shield-Blue Cross plans, the commercial carriers, and the health cooperatives have all been bidding strenuously for this business.

Pending legislative action, the Civil Service Commission has been running the show. Its function is to draw up a list of "approved" health plans and policies. Last month its recommendations were almost ready for unveiling.

How have doctors reacted to this plan? Some are concerned about centralized control; they don't like the idea of national contracts negotiated in Washington for uniform health benefits throughout the country.

He Denies It

But Philip Young, chairman of the Civil Service Commission, denies there is any such intent. A new bill is being prepared for Congress at this writing; and it will probably reflect his emphasis on local negotiations, variable benefits, and "plans best suited for employes in a given geographic area."

This proposal, more than most others, seems to suit the mood of the present Government. It would use limited Federal funds (perhaps $65 million a year) to extend health-plan enrollment (perhaps with dramatic speed). It thus appeals to

both the Republican Administration and the Democratic majority in Congress. Barring last-minute upsets, it must be rated as the health legislation most likely to succeed.

The Uninsured

2. *Count on renewed Administration pressure for Federal reinsurance of the voluntary health plans. And count on Congressional efforts to sidetrack it in favor of broader Federal subsidies.*

About 60 million Americans today have no insurance against high health costs. What to do about them threatens to split the two dominant forces in our present Government.

As the Administration sees it, some 30 million of these people are uninsurable. According to Mrs. Hobby, the President's chief spokesman on health: "This group is made up of indigent people, those already chronically ill . . . and those people in various institutions." Instead of insurance, these people need more local "welfare programs and private charity."

That leaves an estimated 30 million people who can afford health insurance but who don't have it. Why don't they have it? Because the Administration feels, the insurance offered them isn't an attractive enough buy.

What Ike Wants

The President is sold on the idea of making voluntary health insurance a better buy. He wants carriers to experiment with broader coverage and marginal risks. He wants $25 million in Federal funds to help reimburse them for abnormal losses. "In this way," according to his health spokesman, "we can compress the experimentation of the next twenty years into less than half the time . . ."



Rep. J. Percy Priest



Dr. Frank E. Wilson

While this reinsurance plan has strong support within the Administration, it has relatively little outside. Doctors and insurance men are cool to it; the House of Representatives has already voted it down once.

Since the Democrats regained control, their opposition to the plan has sharpened. Many now ask a question first raised by Representative Abraham Multer (D., N.Y.): "If this is such a good plan, why can't the insurance companies carry it out [and] invest their *own* $25 million, rather than have the Federal Government get into it?"

The Hill Plan

The Democrats would prefer to subsidize patients rather than health plans, while still using the latter as intermediaries. That's what they have in mind for the bulk of the country's 60 million uninsured.

The Congressional majority says, in effect: "Medical care for families that aren't self-supporting should be financed by all levels of government. Provided there's required matching of Federal, state, and local funds, the drain on the national treasury shouldn't be too great."

The drain would be great enough, however, to make an Eisenhower veto almost certain. Unknown hundreds of millions would be required each year, with no end in sight. Senator Hill has introduced such bills in the past, and he'll undoubtedly try again. But during the current session, his plan and the President's plan may tend to cancel each other out.

What about national compulsory health insurance? The scheme still has its diehard supporters in Congress—Senator James E. Murray (D., Mont.) and Representative John D. Dingell (D., Mich.), to name the most vocal ones. You can



Chairman Philip Young



Sen. Frank Carlson

expect periodic outbursts from these legislators, now that their party is back in control. But no one will take them seriously for the next two years at least.

Doctors in Uniform

3. *Expect the beginning of a new medical officer procurement program, the possible end of the present Doctor Draft. And expect some changes in the medical care of military dependents.*

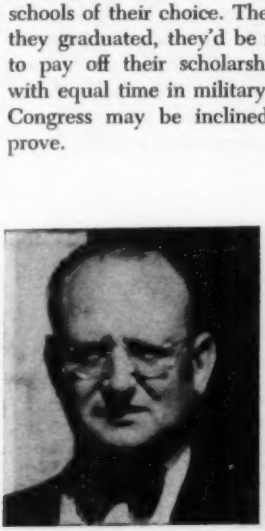
Public Law 779, under which doctors up to 51 years of age had to register with Selective Service, expires this June 30. Defense officials haven't asked to have it renewed. They hope they can get enough military medical officers through a new plan called the "Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program."

This new plan depends on continuance of the regular draft, with service-obligated young physicians available until age 35. Eligible physicians in this group will eventually have to serve two years or more. But none will ordinarily be called until completion of their interneships; and those who accept reserve commissions may win further deferment for residency training.

This forced-draft commissioning should meet the services' immediate needs. But for the longer pull, Assistant Secretary of Defense Frank B. Berry wants a program of military medical scholarships. As Dr. Berry envisions it, the Federal Government would pay for the medical education of selected students in schools of their choice. Then, when they graduated, they'd be required to pay off their scholarship years with equal time in military service. Congress may be inclined to approve.



Rep. John D. Dingell



Rep. Abraham Multer

"More reliable medical care" for military dependents is also being pushed. Service families have come to expect such care, and doctors in uniform can't always provide it. President Eisenhower is keenly aware of the effect on morale (both military and medical). And, with the help of a Democratic Congress, he may be able to do something about it.

Private physicians might well play a larger part in the dependents' care program now taking shape. One tentative proposal is that they be authorized to bill the military direct for such care. Dependents would pay the first $10 out of their own pockets (except in maternity cases) plus 10 per cent of the total bill. The military would pay the rest—"reserving the right to consult with the local medical society in cases where charges appear to be excessive."

In this controversial field, almost any proposed changes are bound to be compromised. (One compromise already put forward is Government-financed Blue Cross and Blue Shield coverage for service families.) But signs are that some changes will actually go into effect. The political climate favors them this year.

Social Security Moves

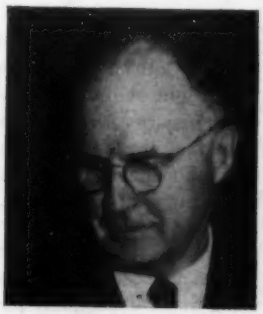
4. *Watch for further moves to bring private physicians into the Social Security system. But don't bet on final action this year.*

Ten million more Americans were brought under Social Security last year. Self-employed physicians just missed being included. Congressional committees exempted them at the last minute, largely on the strength of the argument that "there is no sound reason for compulsory coverage of a group against their expressed wishes."

Actually, private physicians are



Sen. James E. Murray



Dr. Frank B. Berry

divided almost evenly on the issue. This probably militates against their being left out indefinitely. So does the dwindling number of occupational groups still outside (self-employed lawyers and dentists being the other main holdouts).

Voluntary coverage would be more popular with the profession than the compulsory brand. So far, Social Security experts have insisted that giving doctors an option would bring into the system only the "bad risks." But optional coverage has been available since 1951 to employes of nonprofit organizations; and last year it was extended to clerygmen and Christian Science practitioners. The possibility remains that doctors can get it too.

Who Gets Tax Relief?

Medical societies have pushed instead for tax deferment on money put into pension plans. This would permit a doctor to pay perhaps 10 per cent of his annual income into a privately managed retirement fund—such sums to be tax-exempt until drawn out after retirement. But the outlook for this legislation isn't bright at present. The Democratic majority is more interested in providing tax relief for people who can't afford their own pension plans under any circumstance.

Voluntary or compulsory, some sort of Social Security coverage for physicians seems more likely. The thing that will probably postpone it into another year is the vast effort expended on Social Security revisions just last summer. Congress isn't anxious to resume the ordeal without a breathing spell.

They're Here Again

5. *Be prepared for renewed agitation in behalf of Federal aid to medical schools, Federal aid to local health units, Federal aid to group clinics.*

Twice in the past, the Senate authorized Federal funds for medical schools; but the House never followed through. Since then, voluntary fund-raising has picked up some of the slack.

The National Fund for Medical Education now collects more than $2 million a year. But the fund's president, S. Sloan Colt, points out that "the total still falls far short of the schools' annual need of $10 million." The deans say Federal aid is essential. Even the A.M.A. has cautiously endorsed Federal grants for construction needs.

Federal aid might thus seem a near certainty—except for two things:

One is the inertia that has enveloped the project, after almost a decade of discussion on Capitol Hill. It will take a powerful head of steam to drive the legislation through to the White House this year.

Then there's the possibility of its cool reception by the President. He helped organize the voluntary National Fund. He once described Government support of medical educa-

tion as "the first step toward the socialization of medicine." And just recently he spoke of the critical importance of "making certain that our medical schools have ample funds from private sources . . . because this is one profession we don't want to get under the dead hand of bureaucracy . . . "

The prognosis? It's too early to tell. But this legislation could disappear down the crack between the two branches of our politically divided Government.

Less Urgency Now

Federal aid to local health units is another legislative perennial. It almost passed during the Korean War, when the defense aspects were in every legislator's mind. Some 50 million Americans then lived in areas that lacked full-time public health services. They still do. But it's doubtful if the same sense of urgency can be whipped up in Washington this year.

A newer and possibly more attractive idea is Government-sponsored loans for group clinics. Labor unions and other lay groups are behind it; so are some group-minded doctors.

Henry J. Kaiser is the most ardent proponent of all. If such legislation were enacted, he says, "thirty doctors in an area could raise a million dollars of private capital, build a medical center, and provide comprehensive care to 30,000 health plan members."

Relatively few people in Washington share Mr. Kaiser's natural enthusiasm. But if the scheme's value is strictly limited, so is its cost. Government-sponsored loans are sometimes an easy way to please important blocs of constituents. And given strong support by key Democratic legislators, this measure could conceivably slip through without drawing a veto.

Which suggests an unspoken question that will be applied to all health legislation this year and next. Out loud, you'll be hearing: "Will this help the people?" You can translate the pause that follows to mean: *"Will this help our party?"*

Joined in competitive conflict, the Republican Administration and the Democratic Congress are already jockeying for position in 1956. But don't be surprised if an occasional health bill attracts the backing of both. END



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Voluntary coverage would be more popular with the profession than the compulsory brand. So far, Social Security experts have insisted that giving doctors an option would bring into the system only the "bad risks." But optional coverage has been available since 1951 to employes of nonprofit organizations; and last year it was extended to clerygmen and Christian Science practitioners. The possibility remains that doctors can get it too.

Who Gets Tax Relief?

Medical societies have pushed instead for tax deferment on money put into pension plans. This would permit a doctor to pay perhaps 10 per cent of his annual income into a privately managed retirement fund—such sums to be tax-exempt until drawn out after retirement. But the outlook for this legislation isn't bright at present. The Democratic majority is more interested in providing tax relief for people who can't afford their own pension plans under any circumstance.

Voluntary or compulsory, some sort of Social Security coverage for physicians seems more likely. The thing that will probably postpone it into another year is the vast effort expended on Social Security revisions just last summer. Congress isn't anxious to resume the ordeal without a breathing spell.

They're Here Again

5. *Be prepared for renewed agitation in behalf of Federal aid to medical schools, Federal aid to local health units, Federal aid to group clinics.*

Twice in the past, the Senate authorized Federal funds for medical schools; but the House never followed through. Since then, voluntary fund-raising has picked up some of the slack.

The National Fund for Medical Education now collects more than $2 million a year. But the fund's president, S. Sloan Colt, points out that "the total still falls far short of the schools' annual need of $10 million." The deans say Federal aid is essential. Even the A.M.A. has cautiously endorsed Federal grants for construction needs.

Federal aid might thus seem a near certainty—except for two things:

One is the inertia that has enveloped the project, after almost a decade of discussion on Capitol Hill. It will take a powerful head of steam to drive the legislation through to the White House this year.

Then there's the possibility of its cool reception by the President. He helped organize the voluntary National Fund. He once described Government support of medical educa-

tion as "the first step toward the socialization of medicine." And just recently he spoke of the critical importance of "making certain that our medical schools have ample funds from private sources . . . because this is one profession we don't want to get under the dead hand of bureaucracy . . ."

The prognosis? It's too early to tell. But this legislation could disappear down the crack between the two branches of our politically divided Government.

Less Urgency Now

Federal aid to local health units is another legislative perennial. It almost passed during the Korean War, when the defense aspects were in every legislator's mind. Some 50 million Americans then lived in areas that lacked full-time public health services. They still do. But it's doubtful if the same sense of urgency can be whipped up in Washington this year.

A newer and possibly more attractive idea is Government-sponsored loans for group clinics. Labor unions and other lay groups are behind it; so are some group-minded doctors.

Henry J. Kaiser is the most ardent proponent of all. If such legislation were enacted, he says, "thirty doctors in an area could raise a million dollars of private capital, build a medical center, and provide comprehensive care to 30,000 health plan members."

Relatively few people in Washington share Mr. Kaiser's natural enthusiasm. But if the scheme's value is strictly limited, so is its cost. Government-sponsored loans are sometimes an easy way to please important blocs of constituents. And given strong support by key Democratic legislators, this measure could conceivably slip through without drawing a veto.

Which suggests an unspoken question that will be applied to all health legislation this year and next. Out loud, you'll be hearing: "Will this help the people?" You can translate the pause that follows to mean: *"Will this help our party?"*

Joined in competitive conflict, the Republican Administration and the Democratic Congress are already jockeying for position in 1956. But don't be surprised if an occasional health bill attracts the backing of both. END



Your Federal Ta

January 15

File your final income tax return for 1954 and pay the balance due. *Or* pay the balance of your estimated income tax for 1954 (remembering that if this fourth installment doesn't make the total *paid* equal to at least 80 per cent of the total *due*, you may have to file an amended estimate to avoid penalty for underestimation).

January 31

File Form 941 (including Schedule C, on the reverse side) and pay amounts due. File, with 941, the original copy (or copies) of Form W-2, and give each employe his duplicate and triplicate copies. Form 941 shows income and old-age benefit taxes withheld quarterly from your employes' salaries. Schedule C totals these tax withholdings for 1954. If you had eight or more employes in 1954, file Form 940, and pay Federal unemployment tax.

April 15

File your final return for 1954 if you haven't done so already, and pay the balance due. File your declaration of estimated tax for 1955 and pay one-fourth the total estimated tax.

April 30

File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the first quarter of 1955. Pay amounts due.

Timetable for 1955*

Pay second quarterly installment of your estimated 1955 tax; or file an amended declaration. Make sure that the sum of your first and second quarterly installments is equal to at least half your total estimated tax for the year.	**June 15**
File renewal application for Federal narcotic tax stamp, together with inventory of narcotics presently on hand.	**June 30**
File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the second quarter of 1955. Pay amounts due.	**July 31**
Pay third quarterly installment of your estimated 1955 tax; or file an amended declaration. Make sure that the sum of your first, second, and third quarterly installments is equal to at least three-quarters of your total estimated tax for the year.	**September 15**
File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the third quarter of 1955. Pay amounts due.	**October 31**

*Whenever dates shown fall on Saturday or Sunday, tax returns are due on the next business day.

Who's Right—the A.M.A. Or the Legion?

The American Legion wants to broaden V.A. care; but the A.M.A. claims it's already too broad. Result: a tug of war that does nobody any good

By William B. Walsh, M.D.

● Whenever the American Legion feels like dropping a blockbuster on the medical profession (which is, unfortunately, fairly often), it's likely to let fly one of these three indictments:

1. The A.M.A. is anti-veteran;
2. The A.M.A. doesn't really represent doctors;
3. The A.M.A. dictates to its members.

Such charges may impress the public; but you and I know they're nonsense. Take the anti-veteran accusation, for example:

What veterans' organization can claim a more willing participation in past wars than the A.M.A.? Of the 60,000 medical men who put on uniforms in World War II, less than 300 had to be drafted. Dr. Walter B. Martin, president of the A.M.A., saw far more military service than many of those who now accuse him of leading an anti-veteran crusade.

What about the claim that the A.M.A. isn't representative of its membership? Well, of course, if there's even

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DR. WALSH, a Washington, D.C., internist, is president of the National Medical Veterans Society. The views he expresses in this article are, of course, his own and not necessarily those of MEDICAL ECONOMICS.

a germ of truth to this, it's your fault and mine. We're the A.M.A. We shape its policies.

Actually, it's a hard fact that the A.M.A. represents doctors far better than the Legion represents veterans. About three-quarters of all U.S. physicians belong to the A.M.A. The Legion can claim only 15 per cent of the total veteran population.

The third charge—that the A.M.A. dictates to its members—seems particularly empty to me. For, in a sense, I personally am evidence that the A.M.A. is anything but autocratic.

I now head an organization that grew up because many doctor-veterans disliked the way the A.M.A. was handling such matters as the doctor draft. Certainly, if the Association were as despotic as the Legion says it is, we'd have been slapped down long ago. In actual fact, the A.M.A. has *helped* us grow. (I wonder, in passing, what chance a similar group might have in the ranks of the American Legion.)

I must emphasize that all of us in the National Medical Veterans Society are A.M.A. members, too. We agree with many A.M.A. policies; but we disagree with others.

So, in the present dispute over the shape of veterans' care in this country, we view things both as doctors and as veterans. We don't feel bound to agree with everything the A.M.A. says or does. Nor are we swept along on a great wave of Legion emotion.

We want to see America's veterans get all the free medical care they're entitled to. But we strongly oppose any effort to turn the Veterans Administration hospital program into a full-scale handout.

In that respect, we medical veterans see eye to eye with the A.M.A. Fundamentally, we go along with the June, 1953, resolution in which A.M.A. delegates demanded that free V.A. care be dispensed to only two

XUM

classes of veterans: (1) those with service-connected disabilities; and (2) those unable to pay for private care of TB or neuropsychiatric ailments.

At the same time, we can't help regretting that the resolution was so strongly worded and so seemingly unyielding in tone. Until June, 1953, Legion-A.M.A. relations had been guardedly friendly. But once the A.M.A. declared such open war on V.A. hospital policies, the result was inevitable:

The Legion reacted with a violence that could have been foreseen. And the cannonading went on and on—until it reached an ugly peak in the summer of 1954, when California Legionnaires passed an incendiary resolution of their own.

It charged the A.M.A. with "a vicious attack . . . against the care of sick and disabled war veterans by the Federal Government." And it added that the A.M.A. "insinuates that the mere fact one is a veteran should be considered as prima facie evidence of dishonesty."

Dr. Murray Replies

Stung by these accusations, the Journal A.M.A. printed a searing editorial that quoted Dr. Dwight H. Murray, chairman of the A.M.A. board of trustees. Dr. Murray labeled the Legion charge "a deliberate, outright distortion." And he went on: "It is unfortunate that the American Legion, a minority group among veterans, cannot consider the [V.A.] problem . . . with intelligent concern for all the medical, social, and economic factors involved—and without resort to hysterical smear tactics."

As I look back, I must say that I agree with the contents of the A.M.A. editorial; *but* I deplore its timing. It appeared in late August, on the very eve of the American Legion's 1954 national convention. And it led to even greater hysteria.

Obviously enraged, Legion lobbyist Robert M. McCurdy shouted that the time had come "to kick [the A.M.A.] in the teeth." Equally aroused, Arthur J. Connell, then commander of the Legion, promised to "urge the Legion to accept the gauntlet thrown down by the A.M.A."

Said Connell, summing up the situation: "As long as they are looking for a fight, we intend to see that they get a battle." And, dutifully, Legion delegates proceeded to pass a resolution condemning the A.M.A. for "a continued, unwarranted attack on veterans."

So there's sound, and there's fury; and there may yet be a pitched battle over the future of Veterans Administration medicine. Meanwhile, as two great organizations kick the V.A. football back and forth, the American taxpayer is the fellow who suffers.

For nothing is being done to correct the wastefulness of the V.A. hospital program. And nothing is being done to stop the V.A. from

ladling out bigger and bigger amounts of free care to veterans who don't need it.

The abuses of the program are apparent to anyone who examines it. Let me illustrate with a few well-authenticated stories:

'Sign the Book'

I'll begin with a simple case, the truth of which has been sworn to by the persons involved:

Four doctors who serve as consultants to a Midwestern V.A. hospital were recently called in to the hospital and asked to "sign the book," so that each of them could be paid a $50 consulting fee. The hospital's budget had to be used up, they were told, or a similar budget couldn't be justified for the next fiscal year. The doctors refused absolutely to sign, since there were no patients for them to see; as a result, the hospital director called them "uncooperative."

A shocking case? It is, indeed. But, as many of us know, it's far from unique.

As another instance of the waste



"The doctor says I'm now in perfect physical shape . . . Doing anything tonight?"

of the taxpayer's money, consider how V.A. hospital admissions are often mishandled:

Ed Klinger, a reporter for the Evansville (Ind.) Press, not long ago wrote an account of the situation at the Indianapolis V.A. hospital. One item in his report: Receiving clerks were admitting patients without even checking to see whether or not their disabilities were service-connected.

Anybody Welcome

Klinger quotes one war-crippled patient as saying: "During my two weeks in that hospital, I was the only service-connected patient I had knowledge of. There probably were others—I failed to find them."

Or take the Long Beach, Calif., V.A. hospital. A survey last spring turned up these facts: Of 1,275 veterans admitted during a single month, 957 had no service-connected disabilities. And 143 of the other 318 were in the hospital for conditions having nothing to do with their service-connected ailments.

Thus, only 175 patients—14 per cent of the over-all total—actually entered the Long Beach hospital for treatment of conditions that stemmed from their military service.

The most dramatic proof of the current abuse is to be found in the V.A.'s own figures: At the end of the last fiscal year, V.A. hospitals had a waiting list of 22,613 veterans. Only three of these men had service-connected ailments!

It's no accident that so many former servicemen flock to Veterans Administration hospitals for treatment of acute ailments or for elective operations. The V.A. seems to go out of its way to encourage this practice.

Late last September, reporter Roy Gibbons of the Chicago Tribune looked into the situation at a local V.A. hospital. Then he sat down at his typewriter and wrote this story:

"The seventeen-story Veterans Research Hospital on Northwestern University's downtown medical center campus has only 184 patients, it was disclosed yesterday. The hospital has beds for 516 . . .

"Dr. William W. Fellows, manager of the $14 million institution which opened last Dec. 7, said he is contemplating making the rounds of the 'turkey and peas' banquet circuit to acquaint veterans groups and other organizations with the hospital's facilities. 'What we need more than anything else is patients,' he said.

"Fellows said the lack of patients is the result of the public's erroneous belief that the institution is primarily a research establishment whose accommodations are reserved only for difficult cases referred to it from other V.A. installations.

'We Want Patients'

"'The hospital, he explained, will accept any kind of medical or surgical case involving a veteran . . . A hospital must have patients before

it can inaugurate a clinical research program, he said.

"To qualify for admission, Fellows explained, the applicant must show that he needs hospital care, and, if his illness is of non-service-connected origin, he must demonstrate his inability to pay for treatment. He need not, however, take a pauper's oath or prove he is indigent.

"Fellows said the V.A. believes that sick veterans should be admitted without requiring them to wipe out any small reserves they may have, to pay for what may be a long term of hospitalization."

The V.A. Explains

You might think V.A. spokesmen would blush when confronted with a report such as this. Far from it. Here's an unblushing explanation of the situation, as offered by Dr. Derrick T. Vail, a special medical adviser to the V.A.:

If veterans' care were limited only to service-connected cases, V.A. medicine would "rapidly sink to a very low level." For unless there is a wide variety of interesting cases, "the V.A. will not attract the exceedingly high type of physicians required for the first-class professional care of the sick."

If V.A. hospitals aren't kept open to all veterans, continues Dr. Vail, "the present essential and valuable resident program will disintegrate ... The veteran . . . will be given indifferent care by incompetent medical hacks and politically appointed lame ducks [who are] the only ones interested in sinecures that offer neither stimulating problems of diagnosis nor opportunities for advancement in education and possibilities for research."

Spiraling a Danger

There's lots wrong with this argument. But let's concentrate on its main point: that V.A. hospitals must be filled with all kinds of patients, so that the chronic cases will get superior care. Logically, according to current statistics, this means there should be about eighty-five non-service-connected for every fifteen service-connected cases. As a theoretical result, top-drawer doctors would be drawn into each V.A. hospital—to the everlasting benefit of physicians and patients alike.

But just suppose that all existing hospitals were jammed to the rafters with interesting, if non-service-connected, cases. Then wouldn't the



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PER CENT CHANGE IN CALCULATED IONIC CALCIUM

GROUP	CHANGE
Control. No medication	Minus 6.0%
No neuromuscular symptoms. Medication, CALCISALIN	PLUS 12.5%
Neuromuscular symptoms. Medication, dicalcium phosphate supplement	Minus 0.9%
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*From *Calcium Metabolism in Pregnancy*, Gross, Wager and Loving, Bulletin Margaret Hague Maternity Hospital, Dec. 1953.

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FACTS...

ABOUT CALCIUM AND PHOSPHORUS IN PRE... DIETARY SUPPLEMENT

● Pregnancy depletes ca... and the principal purpos... prenatal supplement is t... plenish calcium in the ma... pool.

● There is an antipathy be... calcium and phosphorus ... causes depression of ca... levels when phosphorus i... ministered *with* calcium.

● Most prenatal supplem... excepting Calcisalin, use ... cium *phosphate* as a ca... source.

● Calcisalin omits phosp... through the use of calc... *lactate*, and also includes ... num hydroxide gel to ... excess *dietary* phosphorus.

● The proven result is ... Calcisalin builds ionic calc... more effectively than su... ments which employ a p... phorus component.

● The medical literature p... more and more strongly ... calcium *lactate* as the calc... salt of choice in prenatal s... tion. In Calcisalin, calcium ... tate and aluminum hydro... gel are combined with iro... required vitamins.

...DO Newark Avenue, Jersey Ci...

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V.A. have to go out and build still more hospitals—to be filled in their turn with still more stimulating cases?

This could become a never-ending spiral. For, don't forget, there are now 20 million veterans in the U.S.—with another million being added to the pool each year.

The V.A. and the Legion apparently want free care for about half the U.S. male working population. It's surely but a small jump from this to the kind of all-inclusive Government medicine we all say we hate.

Where Doctors Err

The A.M.A. must bear its share of responsibility for the current trend toward an ever bigger V.A. medical program. At the end of World War II, when the idea of a Veterans Administration residents' program was worked out, the A.M.A. gave at least tacit approval to the plan. Obviously, this program has been at least partly responsible for the current accent on non-service-connected cases.

Now I don't mean to suggest that our original willingness to put up with the V.A. residents' program should hinder us from taking a different view today. But I do feel that since we've helped make the mess, we'd do well to help clean it up.

Instead, it sometimes looks as if organized medicine is willing to do nothing but view with alarm and cry havoc. Surely the A.M.A. could take a more positive position. It rightly opposes the V.A.'s unchecked growth. But instead of decrying *all* treatment of non-service-connected cases, why can't the Association recommend some workable formula for sharply limited care of such patients?

Perhaps, if the A.M.A. did so, the Legion would show a willingness to compromise. As a result, the very real threat of Government medicine for all would diminish.

Size of the Program

And—let's not deceive ourselves—it *is* a real threat that the V.A. empire now poses: The agency already operates a chain of more than 170 hospitals. It already employs 4,000 full-time and 3,000 part-time doctors, plus 130,000 hospital workers—many of them skilled technicians lured from private institutions by high Government pay. [MORE▶



"John Boe . . . Looked out to see if train was coming. It was. Age 23."



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Cyanamid Fine Chemicals

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When you add it up, you find that the yearly cost of this program is close to $750 million.

To be sure, Harvey Higley, present V.A. head, has promised that no more V.A. hospitals will be built once the 174th institution is completed. As proof of this intention, he says that "it would be difficult—if not downright impossible—to provide the medical staff for more than the 128,000 beds contemplated in our present program."

Maybe so. But it's not easy to forget last year's ominous threat from the spokesman for one veterans' organization (not the American Legion in this case), who told Congress that if doctors can be drafted for war service, they can be drafted for V.A. duty, too.

Congress Is Impressed

So far, Congress shows no signs of acting on that suggestion. But it shows every sign of being deeply impressed by a variety of Legion arguments.

It listens gravely when the Legion insists that the U.S. owes veterans a debt because "they're a special class." It nods sagely when told that this debt isn't really hard to pay, since the cost of operating the V.A. is less than 1 per cent of the total U.S. budget. And it seems pleased to hear, too, that only 3 per cent of the veterans—most of them unable to pay for private care—actually use V.A. hospital facilities.

The Legion backs up this last claim by citing a survey of some 6,000 hospitalized veterans. They're said to have gone to V.A. hospitals only after spending $2.5 million with private doctors.

Adds Vice Admiral Joel T. Boone, the V.A. medical director: "More than 35 per cent of the general medical and surgical patients treated in V.A. hospitals are referred to the V.A. by private physicians and hospitals after their funds are exhausted . . . If the V.A. didn't take them, who would?"

What Is a 'Pauper'?

Let's admit it: Admiral Boone has a point here. Those of us who seek an end to abuse in the V.A. program can hardly overlook our colleagues who foist off poor-paying patients on V.A. hospitals.

On the other hand, it's clear enough that only too often the fault is the patient's. Only too often it's the veteran himself who sees no reason to pay his doctor for what he can get free elsewhere.

It's probably true that many veterans have turned to the V.A. only after exhausting their own resources. Yet I'm bothered by the fact that there are no teeth in the V.A. requirement that veterans with nonservice-connected ailments declare their inability to pay.

Nor can I overlook a Government survey of 500 V.A. "pauper" patients, 336 of whom had annual incomes of close to $5,000.

Maybe, as I've said, such difficul-

ties could be ironed out if the Legion and the A.M.A. would try to meet in a spirit of friendly cooperation. But, so far, neither side shows any sign of readiness for peaceful negotiations.

Under the circumstances, I can sympathize with those of my colleagues who'd like to turn their backs on the problem. Yet, I insist, we dare not do so. For the very future of free medicine is at stake.

What, then, can the average doctor do to inject common sense into the arguments over Veterans Administration medical care?

I have three suggestions:

1. If you're a veteran, take part in veterans' affairs. Try to learn what your veteran-patients believe about the V.A. hospital program. Tell them what you think. Perhaps, when they know both sides of the story, they'll change their minds.

2. If you're on the staff of a V.A. hospital and you see examples of abuse and waste, bring them to light.

3. If you feel, as I do, that A.M.A. policy on the V.A. issue isn't all it could be, make your voice heard in your local society. Speak up, and help improve that policy.

Individually, our efforts may seem pretty puny. But collectively we can do much to insure the kind of medical program that will make sense for veterans—and sense for everyone else. END

The Old Back Porch

• I had just graduated from medical school and was home for a short visit with my family. We were all seated on the old back porch, passing the summer evening with friends. Suddenly my mother's cousin, obese and patronizing, broke into the conversation:

"Henry," she said, "now that you are a full-fledged young doctor, I wish you would tell me what's good for boils. I have tried everything."

This was no time for snap diagnosis, I thought; but it *could* be diabetes. So I replied in my best professional manner: "Suppose I take a look at the boil right now."

There was silence, then redness, then fluster. With the luck of the neophyte, I had apparently brought off the perfect squelch.

Tentative diagnosis: gluteal abscess.

—HENRY M. STERN, M.D.



SEBORRHEIC DERMATITIS

Sites and Appearance of Lesions: Favored sites for seborrheic dermatitis are behind the ears (see illustration above), the external auditory canal, scalp, folds of the nose, the presternal and interscapular regions, the folds of the skin at the armpits, groin and intergluteal cleft. The lesions may show moderate erythema, and scaling which is usually yellow. They may be diffuse or patchy, chronic to subacute.

Treatment: 'Pragmatar' is almost invariably helpful in seborrheic dermatitis. Patients with mild seborrheic dermatitis should apply 'Pragmatar' once or twice weekly. In more severe cases, 'Pragmatar' should be applied once daily. Regular applications may be necessary to prevent recurrences.

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—A superior tar-sulfur-salicylic acid ointment incorporating a unique oil-in-water emulsion base.

—Wide margin of safety enhances the usefulness of 'Pragmatar' in patients of all ages.

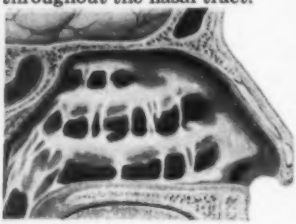
—Pleasant to use; non-staining; not unpleasantly greasy.

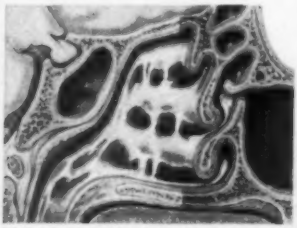
Smith, Kline & French Laboratories, Philadelphia 1

*T. M. Reg. U. S. Pat. Off.

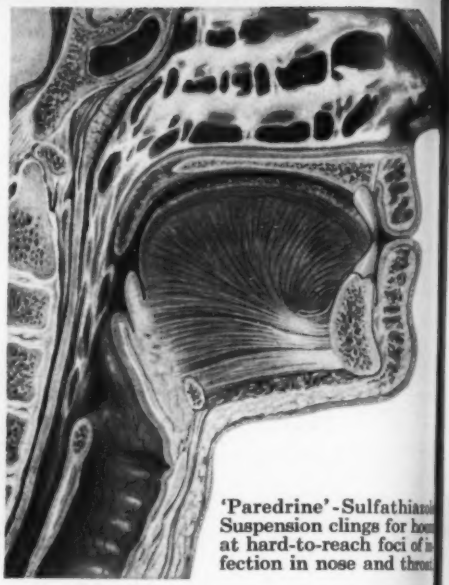
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'Paredrine'-Sulfathiazole Suspension spreads throughout the nasal tract.





Suspension drifts over naso-pharynx, coating inflamed areas.



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Moreover, part of the Suspension drifts down over the nasopharynx and pharynx, giving you the potent, prolonged bacteriostatic action of microcrystalline sulfathiazole precisely where it is needed most, *at the site of infection in the throat.*

Paredrine*-Sulfathiazole Suspension

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

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Is It a Good Idea to Send Reminder Notices?

Most of some 1,200 M.D.s queried by* MEDICAL ECONOMICS *advise asking patients to come in for check-ups. Here, in detail, are their reasons

By Thomas Owens

● Two out of three physicians agree that it's ethical and desirable to remind patients regularly to come to the office for check-ups. What's more, the patients themselves seem to welcome such reminders; a healthy percentage of them respond by turning up as requested.

These are the major findings of a recently concluded MEDICAL ECONOMICS survey. So many doctors had asked us whether *we* thought it advisable to send reminder notices that we decided to solicit the views of a number of experienced medical men. Thus, we put the following questions to over 1,200 U.S. practitioners:

¶ Do you consider reminder notices ethical? If not, why not?

¶ Do you send such notices periodically to your patients?

¶ What means of notification, if any, do you prefer?

¶ How often do you send out reminders, if at all?

¶ What is the attitude of your patients toward such notices?

As I've said, the survey reveals an overwhelming vote in favor of reminders. They're ethical, say most doctors, because they're basically good preventive medicine. A

typical statement—from a Kansas internist:

"For early detection and treatment of disease, the doctor should urge his patients to come in periodically. *We* know that many asymptomatic conditions may be discovered through a routine examination—but our patients don't; and they won't come to see us unless reminded to do so."

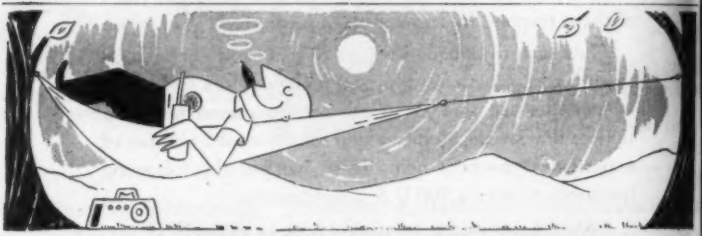
A Wyoming G.P. states the case even more emphatically: "Periodical summonses to the patient are a *compulsory* requirement for preventive medicine."

Other M.D.s justify reminders by pointing out that they're intended to benefit the patient, not the doctor. Says a Georgia physician: "The object of medical ethics is the protection of the patient. So how can a procedure like this be anything but ethical?"

Or, as a New York gynecologist phrases it: "There's no question of ethics here—the primary point is helping the patient."

The doctors of at least one area have made their sanction official: "The Orleans Parish medical society has approved the practice of sending 'reminder notices' to patients," reports a cardiologist from New Orleans.

Another Southern practitioner adds a remark that recurs, in one form or another, in responses from



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Klebsiella pneumoniae 29,000 X

Klebsiella pneumoniae (Friedländer's bacillus) is a Gram-negative capsulated organism commonly involved in various pathologic conditions of the nose and accessory sinuses, in addition to bronchopneumonia and bronchiectasis.

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every section of the nation: "Dentists do it, don't they? So why not physicians?"

Some physicians who strongly favor reminder notices stress their value for specific situations. "I use them especially for immunization treatments; it's about the only way to keep patients on schedule," says a Massachusetts doctor.

But, for the most part, those who advocate getting in touch with patients feel that the chief value of a reminder lies in its preventive-medicine aspect. Many of the doctors also agree that the notice does something more: It improves the doctor-patient relationship.

"Patients feel that if you forget them when they're well, you probably won't be genuinely concerned when they're ill," says a family doctor in New Jersey.

Most Don't Send Them

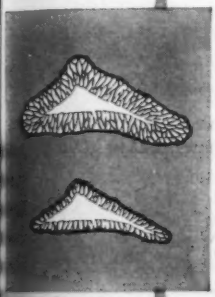
It's a truism that the medical man who applauds a certain procedure doesn't always use it. So it should come as no surprise that reminder notices are actually sent by only one of every three doctors who consider them a good thing. More explicitly, about one out of three sends such notices to *some* patients; only one out of ten says he routinely reminds *all* his patients.

Why this startling gap between precept and practice? "I just don't

after "T & A"
aspergum
and for sore throats
specifically designed to relieve throat soreness through prolonged direct contact of aspirin.
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Q. **Is there a difference between ACTH and THE CORTICOSTEROIDS, cortisone (compound E) and hydrocortisone (compound F)?**

A. **Yes, There *Is* a Difference—and it is clinically significant.**



ACTH is the specific pituitary gland hormone which stimulates the adrenal gland to manufacture and secrete its more than 30 steroids of which cortisone and hydrocortisone are but two.

Only under the influence of ACTH can the function of the adrenal cortex be maintained. While prolonged or intense ACTH therapy lessens the secretion of pituitary ACTH, the adrenals remain functioning and responsive.

Thus, ACTH therapy is stimulation therapy.

Corticosteroids, without exception, cannot stimulate the adrenal cortex. Administration of therapeutic amounts of corticosteroids depress pituitary secretion of ACTH. As a result adrenal cortical function is lessened, and the adrenal may undergo partial or complete functional atrophy.

Thus corticosteroid therapy causes depression of both the pituitary gland and the adrenal cortex.

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New, effective weapon against acute local inflammation:

Restores local circulation, wit



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Safe, compatible, not an anticoagulant. No toxic reactions have been reported following administration of this new, intramuscular form of trypsin. PARENZYME therapy does not preclude the coadministration of other drugs. PARENZYME does *not* alter the clotting mechanism.

with dramatic benefits in

phlebitis	iritis
thrombophlebitis	iridocyclitis
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DOSAGE: *Therapeutic:* 2.5 mg. (0.5 cc.) of PARENZYME (INTRAMUSCULAR trypsin) injected deep intragluteally 1 to 4 times daily for 3 to 8 days. *When more intensive therapy seems indicated, small doses at more frequent intervals ensure better results than larger doses less often.*

MAINTENANCE: To stabilize response to therapy, or in recurrent or chronic diseases, 2.5 mg. (0.5 cc.) once or twice a week may be required for maximum benefit.

Vials of 5 cc. (5 mg./cc.: crystalline trypsin suspended in sesame oil), by prescription only.

Information on PARENZYME and on the research background of clinical enzymology will be mailed on request.

Parenzyme

Intramuscular trypsin

NATIONAL

have time enough to do everything I'd like to," says a typical practitioner. "Too many patients, and not enough office help," says another. Such complaints are echoed and re-echoed all over the country.

But there are other reasons, too—unexpected reasons, considering the general feeling that reminder notices are a good thing:

¶ "I don't send them for fear of criticism by medical colleagues," says a Chicagoan. Adds a Pennsylvanian: "One doctor in our community sends them; and the other men don't think much of him for it."

¶ A few M.D.s seem to feel that the reminder notice—while ethical and desirable—might offend some laymen. "I'd like to send them; but such an innovation in this area could cause too many raised eyebrows among my patients," says a Maryland internist.

'It's Advertising'

What about the minority of physicians who oppose the reminder idea on ethical grounds? Their most frequent objection: "It's too much like advertising."

Says a Tennessee G.P.: "It cheapens the profession." An Eastern ophthalmologist adds: "It's just a business stimulant." And a Texan suggests that "the physician who has to 'remind' his patients in order to get business should move to an area



New advance in the treatment of

✓ **ACNE VULGARIS**

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"Premarin®" Lotion

Conjugated Estrogens (equine) for topical application

- Provides concentration of medication at site of desired action
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Shapiro[1] reports excellent results in 70 per cent of patients of both sexes treated with "Premarin" Lotion for refractory chronic acne of the scarring type. This worker[2] also reports control of scaling, itching of the scalp, and progressive hairfall particularly about the vertex in both men and women treated with "Premarin" Lotion.

SUPPLIED: No. 875 — Bottles of 60 cc. Each cc. contains 1 mg. of estrogens in their naturally occurring, water-soluble conjugated form expressed as sodium estrone sulfate. For convenience of administration, the bottle closure incorporates a specially designed applicator.

Literature available on request.

1. Shapiro, I.: Postgrad. Med. *15*:503 (June) 1954.
2. Shapiro, I.: J.M. Soc. New Jersey *50*:17 (Jan.) 1953.

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OF Bowel Inflammation and Diarrhea

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...a new, orally effective, chemo-therapeutic, anti-mycotic for prophylaxis and treatment*

OF

Intestinal Moniliasis

frequently associated with oral, broad spectrum antibiotic therapy

* "The improvement was dramatic, and by the end of the week the stools were normal in number and character. The patient has gained weight and is able to perform her household tasks." (1)

"The stools were reduced in number from six a day to two or three, and the abdominal cramps were disappearing. One month later a report culture of the stool was negative for C. albicans, and all abdominal symptoms had vanished." (1)

In 100 cases of clinically proved Intestinal Moniliasis encountered over a period of two years, McGivney reports:
"This drug, given by mouth, in doses up to 400 mgms. four times daily, rapidly removed all clinical symptoms and endoscopic findings of moniliasis. Yet, in no instance were side effects encountered. *It is by far the most satisfactory oral moniliacide we have had occasion to use.*" (2)

1. Neuhauser, I.: Successful Treatment of Intestinal Moniliasis with Fatty Acid-Resin Complex. A.M.A. Arch. Int. Med. 93:53, 1954.

2. McGivney, J.: The Anorectal Complications of Broad Spectrum Antibiotic Therapy. In Press.

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For literature, write R. J. Strasenburgh Co., Rochester, N. Y., Toronto, Ont.

Dosage: Treatment—4 capsules q.i.d. Prophylaxis—2 capsules q.i.d. in conjunction with oral antibiotic therapy.

Now Available at leading pharmacies as 'Kaprylex' Capsules, each capsule containing resin caprylate 250 mg. equivalent to caprylate ion 125 mg. bound to polyethylene polyamine methylene resin. In bottles of 100 and 500.

where an M.D. is needed—and really go to work."

A number of physicians indicate that they oppose reminders not because they're "advertising," but because they are—to quote one man—"an invasion of the patient's privacy." Says a North Dakota G.P.: "Reminder notices are a not-too-polite form of pressuring your patients."

But who *are* "your" patients? "Having a fellow's name on a file card doesn't make him my patient," says a New Yorker. And an Alabama OB man adds: "We don't *own* the individuals we treat. Nor has this country yet gone in for a socialistic set-up that requires our patients to do our bidding."

In some areas, this opposition stand has apparently been made official. Doctors of Buffalo, N.Y., point out that their county medical society has ruled out reminder notices; and a Midwesterner says: "Our county society doesn't permit us to send notices to patients even in case of change of address."

But stringent regulations of this sort are rare. In most of the country, the individual doctor is free to send out notices or not, as he chooses.

The survey reveals, interestingly enough, that such notices are actually sent—to at least some patients—by a greater proportion of specialists (30 per cent) than of G.P.s (only 15 per cent). Many of the specialists queried point out that reminders are necessary, of course, in their particular field. For example:

¶ Several cancer surgeons report that they call patients in for post-operative check-ups every three or four months. [MORE▶

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Zone _____ State _____	Zone _____ State _____

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¶ From ophthalmologists comes the word that patients themselves often ask to be reminded of periodic refraction tests.

On the other hand, the G.P.s who use reminders generally do so for less specific reasons. Many of them explain that, as part of their preventive-medicine program, they get in touch only with certain patients who especially need regular check-ups—for example, hypertensives, diabetics, and the middle-aged.

What means of notification do most physicians prefer? Apparently, the most widely used form of reminder is the telephone call. Personal, nonstandardized letters run a fairly close second. Very few doctors use printed notices.

This last finding, by the way, bears out a recent statement by a large printing company that deals extensively with doctors. So few M.D.s order printed reminder notices, says the company, that it will no longer include samples of them in its catalogues.

The surveyed doctors are about evenly divided not only on the best *way* to notify patients, but also on the *frequency* of such notification. About half of those who send reminders do so semi-annually; the other half feel that once a year is often enough. And some specialists report that they call in their patients only once in every two or three years.

Response Is Good

For the medical man who refuses to use reminders for fear of bad patient reaction, the most interesting finding of the survey is this: Practitioners who do use them report striking success. Most of them say that more than 50 per cent of their patients usually respond to routine notification.

They add that patients appear to be grateful for this extra service. Says an Ohio doctor: "Again and again, people tell me how much they appreciate my interest in their continued good health. That's enough to convince me that reminders are worth-while."

Doctor's Dilemma #999

First things first, the sages say,
  Will win us fame's diploma.
But tell me, please, which treatment first:
  The psyche or the soma?

—RAY BLACK



visceral eutonic

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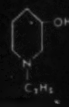
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DACTIL relieves gastroduodenal or biliary pain so quickly that you can usually see it work right in your office.

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Medical Articles I Never Finish Reading

The author says his wastebasket is stuffed with the writings of doctors who won't stick to the point and keep it simple. He explains here what makes their work unreadable

By Henry A. Davidson, M.D.

● As a constant reader and an occasional editor, I used to try conscientiously to plow through the mounds of impassable prose that reached my desk.

But no more. I've made a decision that I suspect a good many other readers and editors will also make—if, indeed, they have not made it already.

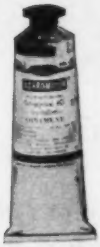
I've decided that if the writer won't say what he has to say in an interesting, clear, and simple fashion, I just won't read it. There are too many medical articles clamoring for the attention of us doctors, as it is.

Scientific prose *needn't* be dismal. It *can* be made readable—even pleasantly so—if the writer will only work at the job. But he's got to make a real effort to capture the reader's attention and to hold it.

Readability begins with the title. If the title looks promising, I'll read the first paragraph of practically anything. If the title is bad, I seldom read further. The good title, to my mind, is short, revealing, and specific. Here's one that scares me off:

DR. DAVIDSON *is editor of the Journal of the Medical Society of New Jersey and a contributing editor of* MEDICAL ECONOMICS.

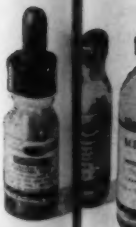
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Dispersible Powder
50 mg. per teaspoonful (3 Gm.)



PEDIATRIC DROPS: *Cher*
Approx. 5 mg. per
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Cherry flavor. 250 mg. per 5 cc. teaspoonful.

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now available in these many convenient forms:



OPHTHALMIC OINTMENT (1%)



TABLETS:
250 mg., 100 mg., 50 mg.



CAPSULES: *250 mg., 100 mg., 50*







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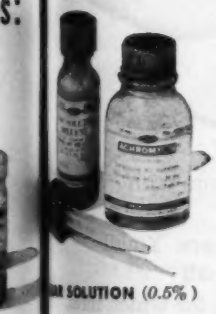
INTRAVENOUS: *mg., 250 mg., 100 mg.*

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ACHROMYCIN, the new broad-spectrum antibiotic, is now available in a wide range of forms for oral, topical and parenteral use in children and adults. New forms are being prepared as rapidly as research permits.

ACHROMYCIN is definitely less irritating to the gastro-intestinal tract. It more rapidly diffuses into body tissues and fluids. It maintains effective potency for a full 24-hours in solution.

ACHROMYCIN has proved effective against a wide variety of infections including those caused by Gram-positive and Gram-negative bacteria, rickettsia, and protozoan organisms.

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THE STRIDE RITE SHOE

DOCTOR: If you are not already familiar with Stride Rites, and with Stride Rite Shoes with Extra Support, write for information to: Green Shoe Mfg. Co., 360 Harrison Ave., Boston, Mass.

"Comparison of Results in the Treatment of Acute Meningococcemia With Shock (Waterhouse-Friderichsen Syndrome) With Sulfonamides, Penicillin, Cortisone and Nor-Epinephrine."

Why couldn't the writer have put it compactly as just "Treatment of Waterhouse-Friderichsen Syndrome." If he felt he *had* to define his subject more narrowly, he could have added a subtitle, such as "Comparative Results With Modern Pharmaceuticals."

Here's another mouthful of a title that actually appeared in print: "Why 2,276 American Soldiers in the Mediterranean Theatre of Operations Were Absent Without Leave, Deserted or Misbehaved Before the Enemy."

I wonder how that one is indexed. In fact, I wonder how a reader could refer back to it without losing his breath.

All I'm saying is: Keep the title simple. But make it specific, too. You won't hook *my* interest, at least, with a title like "A New Diagnostic Sign" or "An Interesting Case."

If the title quickly tells me where I'm going, I'll start the article. But if the first paragraph is dull, or historical, or apologetic, or overstatistical, I'll stop right there.

No Excuses, Please

Let me cite the kind of apologetic opener that makes me take the timid author at his word:

"So much has been written about omphalitis that it seems presumptuous to offer another paper on that subject. Yet . . . "

Or: "It seems unnecessary to present to an audience of this caliber any further studies of logus on the bogus. But . . . "

Well, if it's "presumptuous" and "unnecessary," the learned writers must know what they mean. I thank them for the warning—and turn to the next article.

Yawn Producer

Or take this one: The title—"Modern Treatment of Paralysis Agitans"—promised me some up-to-date information on an important subject. So I began to read the article; but I never got beyond this opening paragraph:

"Although James Parkinson is generally credited with discovery of the syndrome that bears his name, it is obvious that so conspicuous a battery of symptoms must have been known long before 1817, when Parkinson wrote his classic essay, 'On the Shaking Palsy.' Indeed, there is an old Swiss manuscript in the Musee Lucerne, which is generally assigned to the year 1550, which includes a woodcut showing a patient in typical Parkinsonian posture. It is also known that in 1680, Thomas Sydenham in his . . ."

Pardon me if I yawn. History is often interesting; but not to a reader who's been promised something else.

Another opening paragraph that marks the end instead of the begin-

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At long last . . .

The Comprehensive Antispasmodic for both skeletal and associated smooth muscle spasm . . . . . .

EXPASMUS, *a new* combination of antispasmodics, plus a powerful analgesic—in *single prescription form* effectively reduces both skeletal and smooth muscle spasm, while affording more rapid release from pain.

Rx

Though skeletal muscle *pain-spasm* often engenders secondary smooth muscle spasm, no single antispasmodic preparation free of belladonna, barbiturates or amphetamine has heretofore been formulated to treat both types of spasm. In this respect, Expasmus is unique as it combines the smooth muscle relaxant, dibenzyl succinate and the skeletal muscle relaxant, mephenesin with the powerful analgesic, salicylamide to provide safe, fast-acting and *comprehensive* therapy.

Description: Each tablet of Expasmus contains dibenzyl succinate, 125 mg.; mephenesin, 250 mg.; salicylamide, 100 mg. Packed in bottles of 100 tablets, on your prescription only.

Indications and dosage: For relaxation of skeletal and associated smooth muscle spasm; relief of arthritic and low back pain; as a mild non-barbiturate sedative and relaxant in tension —Average dose, two tablets every four hours. Maximum daily dose, twelve tablets.

Samples Available to Physicians

MARTIN H. SMITH CO.
150 Lafayette St., New York 13, N. Y.
Manufacturers of ethical products for over half a century.

EXPASMUS

ning for me is the kind that bristles with figures. I like numbers as much as the next man. I agree that a scientific paper must often have a sound statistical base. But spare me a big, indigestible gob of numerals right off. I was once asked to read a manuscript that began this way:

"According to the United States Public Health Service, there are 6,850,000 cases of all types of joint diseases on any average day. It is estimated by the Department of Labor that 6.5 per cent of these represent functional disability. This means a loss of 542,000 man-days each day. The current Department of Commerce wage average indicates a median per hour of $1.25. This means a loss to the country's economy of $5,420,000 a day and an annual loss . . . "

The editor didn't like this figure-riddled opening any better than I did; so he looked around for something better. When the article finally appeared in print, here's how the first paragraph read:

"One hundred million workdays are lost every year because of arthritis. Few other diseases take so great an economic toll . . . "

Why Be Fancy?

What goes for the title and the opening paragraph goes for the rest of the article, too. It must say something—and say it both directly and simply. It's an odd fact, though, that the doctor who talks simply in the staff room often develops a fondness for fancy language on paper. He wants to impress. Instead, he becomes hard to understand.

To see what I mean, let's examine a few exhibits from manuscripts written by physicians who are probably straight-shooters, good doctors, and plain talkers. Watch what happens when they get "literary":

How He Said It

A colleague of mine said to me one day: "Why doesn't somebody write a book about what you can learn by examining a patient's hand? There are so few articles about it that I guess nobody thinks it's important." A short time later, he did an article on the subject and put that very thought this way:

"The fact that the importance of the subject is insufficiently stressed is proved by the acknowledged paucity of articles on this topic in the



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The new Mol-Iron Panhemic formula in a daily dose of 2 small capsules provides:

- One U.S.P. Oral Unit of antianemia activity fortified with an *additional therapeutic amount of vitamin* B_{12} as a further "safety factor."
- Folic Acid and Ascorbic Acid—therapeutic amounts for those anemias responsive to these essential hemopoietic factors.
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For All Amenable Anemias

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Here is the new
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The daily dose of 2 capsules contains:

Mol-Iron (the superior form of oral iron)*
Ferrous Sulfate..... 1 Gm.
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Vitamin B_{12} with Intrinsic Factor Concentrate..1 U.S.P. Oral Unit

Folic Acid... 5.0 mg. ←doubled
Ascorbic Acid..... 150 mg.

Vitamin B_{12} Activity**.....
..... 15.0 mcg. ←added "safety factor"

Thiamine Mononitrate.....
..... 4 mg. ←added

Riboflavin..... 4 mg. ←added

Nicotinamide... 20 mg. ←added

*Well-tolerated, more effective Mol-Iron is an exclusive, patented, coprecipitated complex of ferrous and molybdenum salts which exhibits unique advantages as a hemopoietic agent.

**as derived from Streptomyces fermentation extractives.

Supplied: bottles of 60 and 500 capsules.

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AND AS AN AID IN ANTIHYPERTENSIVE THERAPY

When an Isolated Crystalline Rauwolfia Alkaloid is Desired

Serpiloid®

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contemporaneous medical literature."

His original statement had been lucid and to the point. Yet, when he wrote it down, it became polysyllabic, "elegant," hard to follow.

A Migraine Case

Here's a slightly less obvious example of what I like to call "medical gobbledygook": "The problem of the causation of migraine has been the subject of much scientific investigation in recent years."

This sentence makes its point all right—but in what a round-about way! "Causation," for one thing, is just a fancy way of saying "cause." And there's no difference between "the problem of the cause of migraine has been investigated" and "the cause of migraine has been investigated." So the eighteen-word sentence can be cut almost in half by writing, "The cause of migraine has been much investigated in recent years."

Of course, just cutting a mass of verbiage in half isn't always a sure cure for empty bombast. Sometimes more drastic surgery is necessary. Take this bit of turgid writing as an example:

"Throughout all medical history, scientific opinion as to the best therapy for this type of fracture has been notoriously divided. Authorities veer from one theory to another, and methods now in vogue have to be revamped later, either because of new modes of therapeutic philosophy, or else to provide a pseudological basis for the rationalization of some new theory."

What does this mean? It means simply that nobody's ever been able to agree on how to treat a certain kind of fracture. But the writer sends big words to do little ones' jobs; and, in so doing, he adorns an unimportant idea with important-looking frills. Actually, the entire passage could probably be left out without doing the slightest damage to his message!

We Get Lost

Here's another thing I ask of the writer who wants me to read his masterpiece:

Don't confuse me. Don't make your sentences so long and involved that I get lost in a jungle of prepositional phrases. Here, for instance, is a veritable Congo-ful of them:

"The experience of war has accelerated the acceptance of the fun-



"I just had lunch!"

Still More Clinical Research Proving the Superiority of

Roncovite

in anemia therapy—

The rapidly expanding volume of clinical research continues to prove the effectiveness and safety of Roncovite in the common forms of anemia.* These clinical studies of the effect of cobalt-iron have produced gratifying results in several types of anemia.

AREAS OF CLINICAL STUDY INCLUDE:

- iron deficiency anemia
- anemia in chronic infection
- anemia in pregnancy
- anemia in infants and prematures

Cobalt in therapeutic dosage exerts a specific erythropoietic effect on the bone marrow. Roncovite provides the supplemental iron to meet the need of the resulting accelerated hemoglobin formation.

–and from 1954 clinical reports

"We agree with Waltner (1930) and Virdis (1952) that iron should be given together with cobalt to obtain the most satisfactory results."[1]

"Evidence suggests that iron and cobalt provide the most effective hematinic for pregnant women."[2]

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check-ups. None of them showed harmful effects despite the large doses."[3]

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Each enteric coated, red tablet contains:

Cobalt chloride ..... 15 mg.
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Each 0.6 cc. (10 drops) provides:

Cobalt chloride ..... 40 mg.
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Each enteric coated, red capsule-shaped tablet contains:

Cobalt chloride ..... 15 mg.
Ferrous sulfate exsiccated ... 0.2 Gm.
Calcium lactate ..... 0.9 Gm.
Vitamin D ..... 250 units

DOSAGE

One tablet after each meal and at bedtime; 0.6 cc. (10 drops) in water, milk, fruit or vegetable juice once daily for infants and children.

***Bibliography of 192 references available on request.**

1. Coles, B.L., and James, U.: The Effect of Cobalt and Iron Salts on the Anaemia of Prematurity, Arch. Disease in Childhood *29*:85 (1954).
2. Holly, R.G.: The Value of Iron Therapy in Pregnancy, Journal-Lancet *74*:211 (June) 1954.
3. Quilligan, J. J., Jr.: Effect of a Cobalt-Iron Mixture on the Anemia of Prematurity, Texas St. J. Med. *50*:294 (May) 1954.

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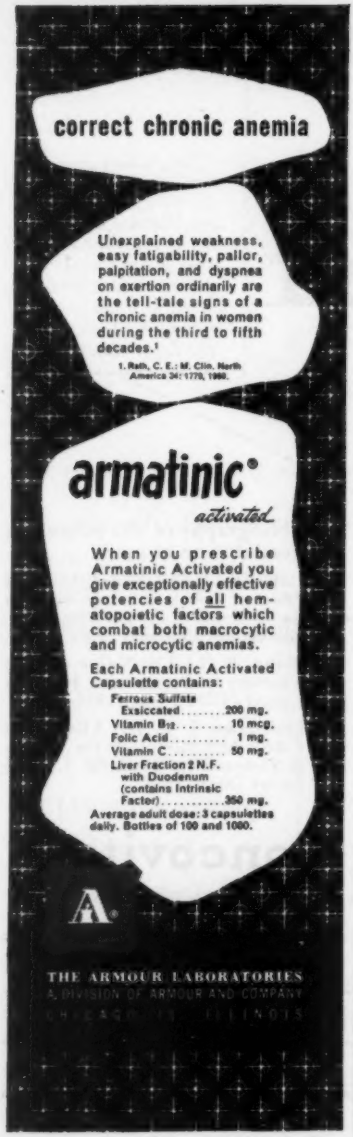
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damental realization of the elemental truth of the importance of the immediate local control of infection."

There you have five "ofs" in one sentence, when all the writer means to say is: "The last war helped us realize . . . " etc.

For an even worse pyramiding of phrases upon clauses upon phrases try this paragraph:

"There has been more and more of a tendency in recent years to demand that conclusive evidence be offered as to the lack of necessity for drainage in the more localized types of peritonitis, before considering a refusal to insert at least a soft rubber drain for a four-day period."

Get it? You do? Then you're better at riddles than I am.

Out of This World

One brand of medical writing I stubbornly resist is the philosophical kind that spirals miles above my whirling head. The following fine example comes from a surgeon I know (he's a plain, practical fellow in the operating room):

"I have been asked to talk about orthopedics in the post-war era. After all, what is an era? We use the word to designate a fixed point of time from which a series of years is reckoned. It is, therefore, entirely appropriate to speak of this present period as an era; for the cessation of World War II was indeed a milestone in the march of time, and these years will now be noteworthy

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Each NEOCYLATE with CORTISONE Entab® contains:

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Potassium Para-Aminobenzoate .	0.32 Gm. (5 gr.)
Ascorbic Acid	20 mg. (1/3 gr.)
Cortisone Acetate	5 mg. (1/12 gr.)

RECOMMENDED DOSAGE: For acute cases, 8 to 10 *Entabs* daily in divided doses. For maintenance, 1 or 2 *Entabs* four times daily.

SUPPLIED: Bottles of 50 and 200 *Entabs* (enteric-coated tablets).

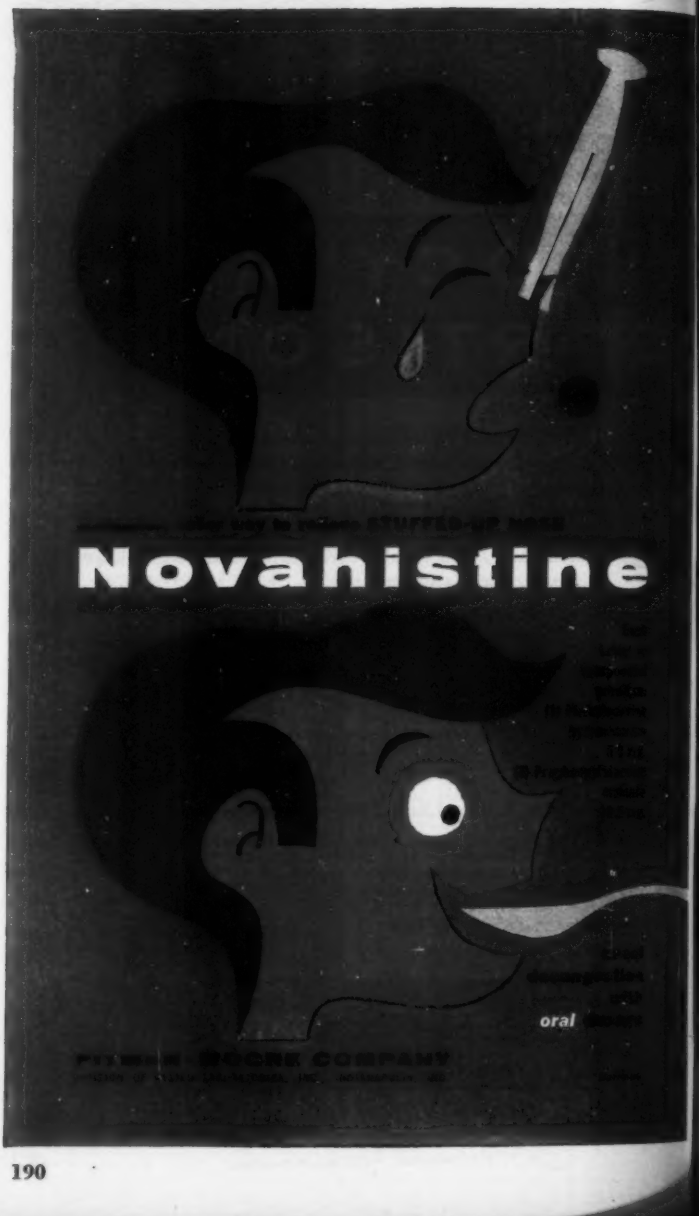
1. Committee of American Rheumatism Association: Primer on the Rheumatic Diseases, J.A.M.A. 152:323, 405, 1953. 2. Robinson, W. D., et al.: Tenth Rheumatism Review, Ann. Int. Med. 39:498, 1953. 3. Dry, T. J., et al.: Proc. Staff Meet., Mayo Clin. 21:497, 1946. 4. Wiesel, L. L., et al.: Brooklyn Hosp. J. 8:418, 1950. 5. Wiesel, L. L., and Barritt, A. S.: Am. J. M. Sc. 227:74, 1954.

Literature on request



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for either good or evil, and present to us all an opportunity, one which may be seized or lost. This holds in all fields of endeavor, not the least in the field of medicine."

This specimen shows not only the doctor's ability to fly off—and crash—on a tangent, but also his addiction to hackneyed phrases. "Milestone in the march of time," "noteworthy for either good or evil," "in all fields of endeavor," "not the least"—these are all badly shopworn. And I wonder why a clear-spoken surgeon is so easily seduced into using ponderous words like "cessation" and "designate."

The Old and the New

Are higher standards of medical education promoting a simpler style of medical writing? It seems not. Here's how one modern medical school teacher has described Addison's disease:

"The exact date of onset is indeterminate. The patient can rarely point with any exactness to the initiation of his sense of lassitude. The facies, on examination, seem pallid; the ocular sclera exhibit translucency; and the patient complains of dyspnea on exertion."

Compare that sluggish mouthful with Addison's original description in 1855:

"This disease makes its approach in so slow a manner that the patient can hardly fix a date to the earliest feeling of languor. The countenance gets pale, the whites of the eyes

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pearly, the frame flabby; and on attempting exertion, there is marked breathlessness."

These two passages both say the same thing; but the modern one is dull, the older one lively and precise.

The samples I've given cover the major flaws of much medical writing, as I see them. But, while I'm at it, I'd like to catalogue also some of my minor complaints. No one exhibit in the following chamber of horrors will turn me forever away from a medical article; but when they appear in combination, I generally make a fast exit:

The space-wasting build-up: "Physical examination revealed a thin, pale, and drowsy child." Why not simply: "The child was thin, pale, and drowsy"? It's almost a third shorter.

Similar space thieves are phrases like "I am convinced that . . . " or "It can readily be seen that . . . " or "Doctors generally recognize that . . ." We readers get restless at the sight of such meaningless locutions.

Sic Semper

Latin: Is there any good reason why the modern physician's writing must glitter with Latin phrases?

I want "measles," not "morbilli." I see no reason for "in situ," "locus minoris resistentiae," and "modus operandi." And when a doctor writes "pes planus" for "flat feet," I simply refuse to trust him. He's clearly a mannered pedant.

Similarly, there's no justification for such terms as "pyrexia" for "fever," "etiology" for "cause," etc. "Gallstones" is English; "cholelithiasis" isn't. And any writer who says "podagra" when he means "gout" would probably say "agrypnia" instead of "insomnia."

M.D. Is O.K.?

Unconventional abbreviations: To you, "P.A." may mean "pernicious anemia." To the radiologist, it means "postero-anterior." And as far as I'm concerned, it's "paralysis agitans."

Which proves there's no booby trap in medical writing quite so dangerous as the loosely used abbreviation. Even the simple letter "O" can stand for eye, pint, oxygen, an electrode opening, or a blood group without agglutinogen.

Split-second percentages: I begin to suspect the authenticity of a medical paper if its author carries percentage figures beyond one decimal point. Does the fellow *really* expect me to believe there's a significant difference between a recovery rate of 87.1 per cent and a rate of 87.13 per cent? In my book, such extraordinary precision also makes the man's findings sound ridiculous.

Editorial "we": Finally, may I be permitted a raised eyebrow in the direction of the solo practitioner who grandiloquently announces: "We have had good results with . . . " when he really means, "I have had . . . " etc.? Does he expect me to believe he's a one-man Mayo Clinic? END



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The Doctor Was a Fake

By Greer Williams

EVER BEEN DUPED by someone posing as an M.D.? It can happen. Some impostures are so shrewdly perpetrated as to deceive nearly everyone.

A recent Saturday Evening Post article presents a case in point: the documented story of Harold Rain, who, as "Dr." Samuel Hall, practiced medicine and surgery in clinics and hospitals for seven years—until he was caught and jailed in 1953.

Rain's story is worth reading simply as an absorbing account of a rogue who hoodwinked hundreds of his betters. It also has an implication for physicians: "The biggest asset of the confidence man," says Greer Williams, is that, to save face, his embarrassed victims "pass him on, unexposed and unhalted," to other dupes.

By special arrangement with the Post, we reprint Mr. Williams' article here, just as he wrote it for that magazine's lay readers.*

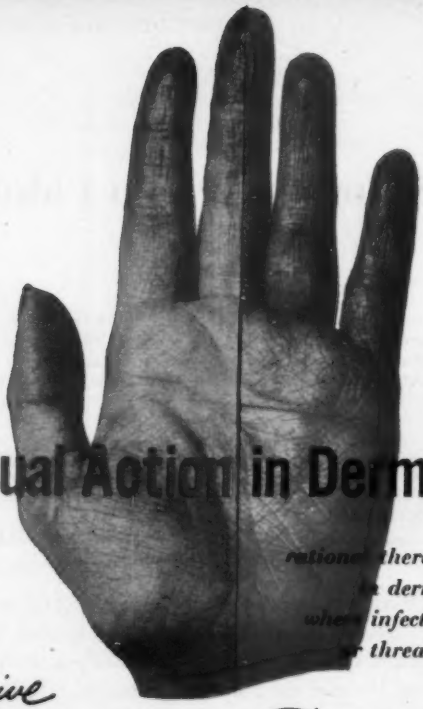
● One of the most successful impostors in recent criminal records is Harold Kenneth Rain, thirty-one years old. For seven years, in eight states, Rain posed and practiced as a physician. He used the name of Dr. Samuel Pike Hall, a gynecologist and obstetrician of Oakland, California, who is a real doctor in good standing.

The strange twists of personality that make an individual drop his own identity and impersonate someone else are, of course, intriguing and familiar subjects of history and literature. At least a half-dozen doctor impostors, a phony physicist and one fake Air Force colonel have been in the news in the last two or three years.

In the length of time he got away with it, the money he made and spent, his rakehell amours and the magnitude of his misdeeds, however, this rascal named Harold was unmatched. He served as a house doctor, company

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doctor, surgeon and obstetrician. He passed as a doctor of medicine who normally requires eight or nine years' higher education before he can so much as take a pulse on a night call, let alone explore the gastrointestinal and genitourinary tracts with scalpel and forceps, as Rain did in his assumed profession.

Rain earned from $175 to $1,000 a month, accumulated an ostentatious wardrobe of fifty suits, drove a succession of new automobiles and acquired the reputation of being a good family man—while he lasted. His qualifications for the role of physician were a public-school education acquired somewhere in California and four years as an Air Force private.

Rain had no degree in medicine. He had no license to practice medicine. He never was a member of a county medical society or the American Medical Association. Yet patients called him "my doctor" and let him deliver their babies, remove their ovaries and uteri, snip off their appendixes, mend their hernias and tinker with their viscera.

One grateful woman upon whom he did a combined hysterectomy and oophorectomy (excision of uterus and ovaries) took him into her home and called him "my son." A friendly surgeon and his wife lent him an antique baby crib, a typewriter and $10,000 to buy a house. On that typewriter Rain faked a letter praising himself and signed his benefactor's name. A Texas businessman let the fake doctor fly his private airplane. Banks made Rain personal loans of $500 to $1,000. Automobile sales agencies gladly handed him the keys to new cars worth $4,000 to $5,000. Credit managers in department stores let him run up thousands of dollars in clothing bills.

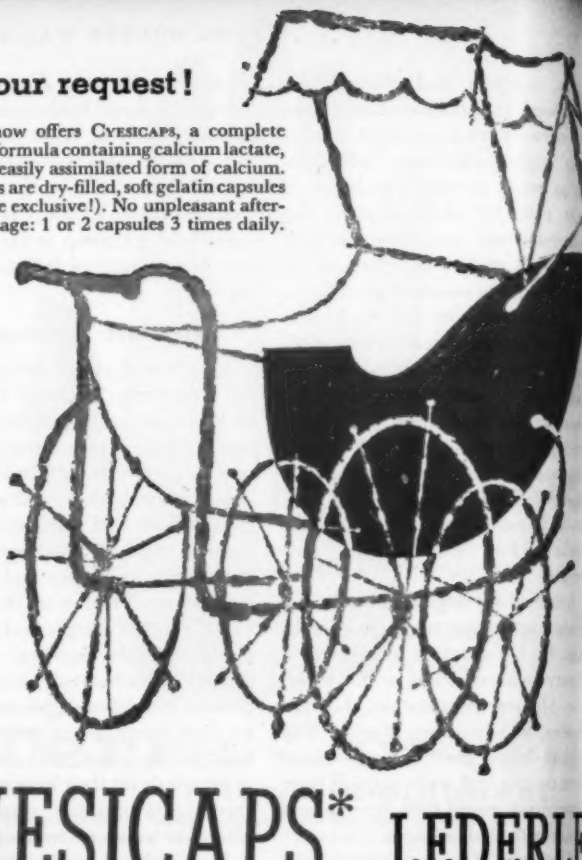
He Hurt Thousands

Rain, the charlatan, left a wake of red faces from the Upper Peninsula of Michigan to the outsize heart of Texas. Those who suffered damage to their dignity, their faith in human beings, their pocketbooks and their lives number in the thousands. They include highly trained specialists—pathologists, surgeons and obstetricians—three Fellows of the American College of Surgeons, two presidents of county medical societies, several goodhearted, roughhewn general practitioners in rural clinics, four hospitals recognized by the Joint Commission on Accreditation of Hospitals for their high standards, three large hospitals approved for intern or resident training by the A.M.A. Council on Medical Education and Hospitals, various nurses and secretaries, two wives and four children.

I have endeavored to retrace the adventures in medicine of Harold Rain and ascertain just how he accomplished his fraud, with the hope that the information will aid others to save themselves from similar situations in the future. In the course

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of working in twelve hospitals, clinics, dispensaries and doctors' offices, Rain seldom aroused suspicion and usually avoided detection until after he left.

Many doctors and nurses with whom he worked spoke of him in glowing terms. "While, in almost a year of professional association with him, I did detect slight flaws in his general knowledge and personal story, I never found a lacuna in his professional equipment," admitted Dr. Richard Birnbaum, of Noble, Illinois, employing a scientific word meaning a blank, or hollow, space.

To Whom It May Concern

Doctor Birnbaum was one of ten physicians who wrote genuine letters of recommendation for "Doctor Hall," who, he said, "has made available to me and this entire area . . . skill of the highest order, and has brought to us the modern advances in these specialties." Others attested this bogus M.D. to be "reliable and dependable" . . . "well grounded" . . . "an excellent physician," of "sound judgment."

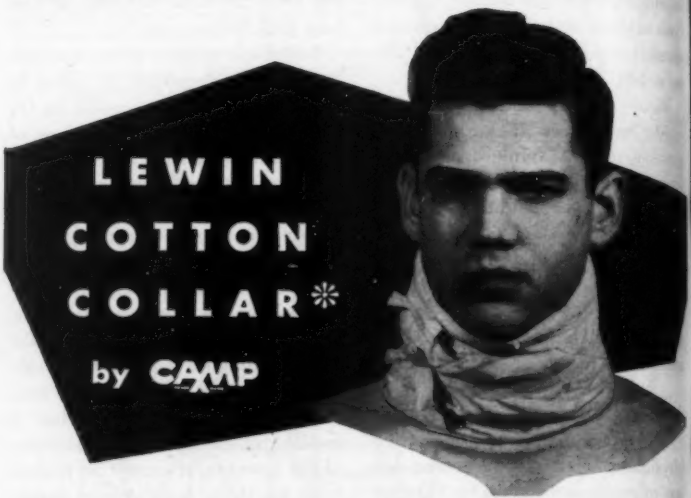
One nurse said that when a patient was in shock she would rather have "Doctor Hall" on the ward than any other resident or intern in the hospital, he was that adept with intravenous injections, blood transfusions and stomach tubes. In one instance, an obstetrician—chief of a department and president of the local medical society—explained he was able to accomplish the exacting procedure of a total hysterectomy in just over an hour because "I had Sam Hall helping me."

Lest these testimonials to the brilliance of his deception be taken to mean that Rain was a good doctor in everything but name, as some of his victims have tried to rationalize, let us refer to one confidential case record. Rain, in this instance, operated on a patient with a strangulated hernia—a surgical emergency which requires a bit of explanation: A hernia, to take the most common type, is the protrusion of a loop of the bowel through a rupture in the abdominal wall. The rupture may strangulate the bowel if, due to swelling of the loop and constriction of the opening, it cannot be pushed back in. If the loop's blood supply is cut off, gangrene sets in and the patient may die.

Immediate surgery is necessary. If the tissue of the bowel is still in good shape when the surgeon opens the hernia, the protruded loop can



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be slipped back into place. This is a routine repair job, one of the most common of all major operations. If the tissue is dark, but not decomposed, the surgeon may apply hot packs to see if the tissue can be restored to healthy ruddiness.

If the tissue is beyond restoration or if it was clearly gangrenous from the start, the surgeon must remove the affected segment of the bowel. If he doesn't know enough to do this, and merely stitches up the hernia, the patient may die of peritonitis.

But here is an even bigger pitfall for a half-trained man who has picked up a little skill at cutting and stitching: if the affected bowel is cut out, the patient will make a good recovery—unless the connecting curtain of tissue and blood vessels also has been bruised. If it has been and is not removed along with the bowel segment, blood clots may form. If they break loose and pass through the blood stream to the heart or lungs, they may produce a thrombosis or an embolism and, quite possibly, death.

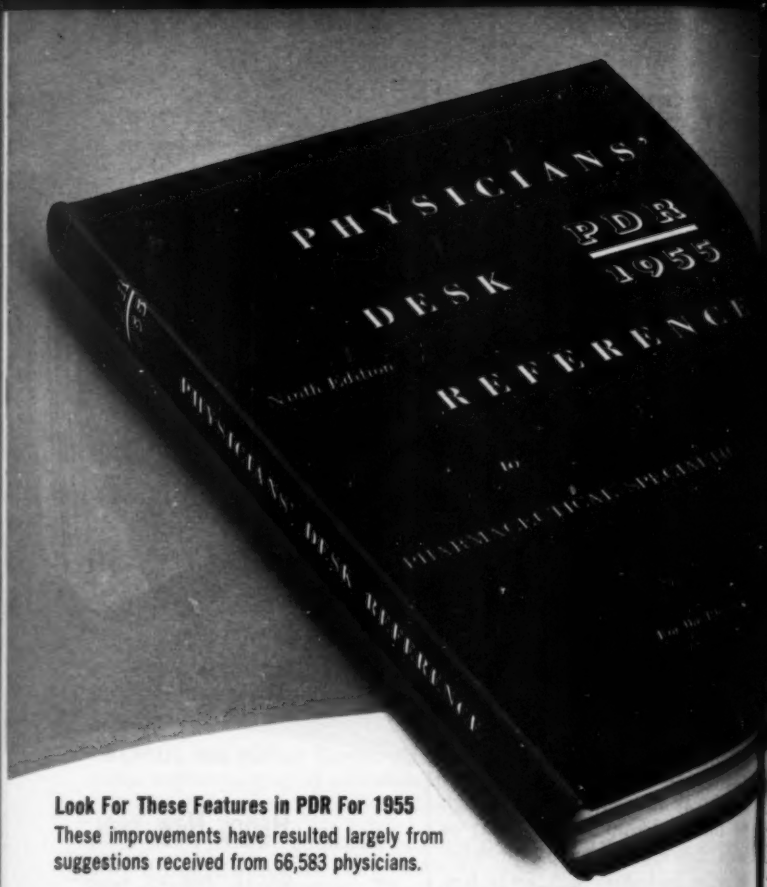
Rain found himself in a situation where he needed this knowledge, which he did not have, and the patient died.

How Did He Do It?

It is easier to understand how a man with a rudimentary conscience and a runaway ego might lie, deceive, steal and even kill to enjoy the power, prestige and income of



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Glenwood Laboratories, Inc.
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(*continued on following page*)

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(continued from preceding page)

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a physician, than it is to see how he could get away with it. How was Rain able to fool knowledgeable, responsible medical and hospital authorities time after time?

At the end of World War II and at the age of twenty-two, Rain arrived in Chicago. He was at loose ends, dissatisfied, homeless, with his head full of GI benefits and rights. "I wanted people to look up to me," he later explained. Making a half-hearted attempt to go to medical school, he found he was lacking in the three or four years' premedical college education needed.

Without registering, he began attending classes with medical students and interns at the University of Illinois College of Medicine and Cook County Hospital—or so he later maintained. His claim cannot be verified, but it may be true. Chicago's West Side medical center teems with students and doctors, and big public institutions are often unwary about identification—everybody is busy and assumed to be about his business.

Looks the Part

About all one would need to drop in on many medical-school lectures would be a youthful but serious demeanor, a white coat and a fountain pen. A stethoscope in one's hip pocket and a copy of Cecil's Medicine or Cole's Surgery under one's arm would ward off all doubt. Before long, Rain had his photograph taken, white coat, stethoscope and all. Dark, alert, smiling, with horn-rimmed glasses to correct his nearsight—20/40 in the left and 20/45 in the right eye—he looked the part.

'Nonprofit Fraud'

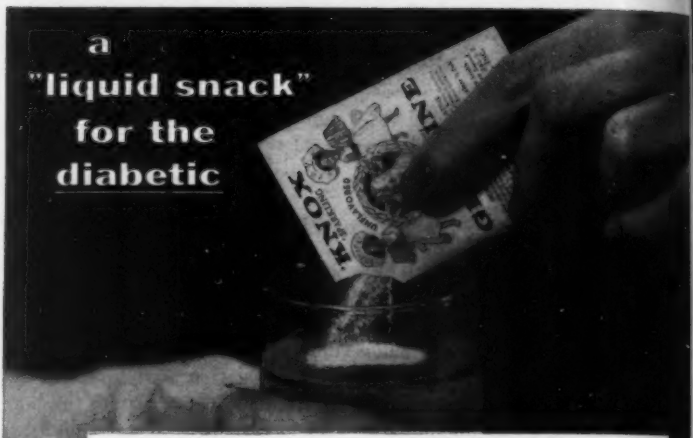
He found it necessary to hurry his medical education along, however, after hearing the radio appeal made by the Hines Veterans' Administration Hospital. This 3,300-bed hospital, just outside of Chicago, wanted doctors to work part time. As the armed forces demobilized, the burden of caring for sick and disabled servicemen shifted to the VA. Because the doctor displacement had been great, the shortage was acute.

Fabricating the name of Dr. Frank Kenneth Hall, Rain called the hospital and offered to donate his services, in a sort of nonprofit fraud. His offer, we may imagine, came as a surprise to the Government worker who interviewed him. His services were needed, but the Government had the money and insisted on paying him.

Filling out the usual application form, our brand-new doctor made random claim to an M.D. degree from Stanford, internship in "Los Angeles General Hospital," and a license to practice in California and in Illinois. He was hired in April, 1946, as an associate in medicine at $4,300 a year. The job, largely the paper work of admitting patients, was ideal for orientation purposes.

In September, however, he left without notice. One day the recep-

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tionist called him and said the FBI was there to see him. The receptionist failed to make it clear that the FBI was interested in a patient on Rain's ward. Rain took off. Subsequently, the VA wrote Stanford University and ascertained from Dr. Loren R. Chandler, professor of surgery and then dean of the School of Medicine in San Francisco, that there was no such graduate.

Rain composed himself after this setback. What he needed, he realized while thumbing through the American Medical Directory, was a ready-made record, to which anyone might refer for a quick check. That of Dr. Samuel Pike Hall seemed quite suitable. He was born in 1915, and therefore Rain, born in 1923, would have to give eight years of his life for a good name. He figured it was worth it—A.B., Stanford, 1937; M.D., Stanford, 1941; internship, Stanford University Hospital, 1942.

Later, he learned that he could add nearly four years' service in the Navy Medical Corps. All he lacked was the 4,156 hours of college and medical-school matriculation which the real Doctor Hall actually had put in.

Noting a classified ad in the back



"Whatever you wanted, you got it!"



in the management of hypertension

The potent autonomic ganglionic blocking action of Methium has now been augmented by the mild hypotensive and sedative properties of reserpine. A true synergistic combination, Methium with Reserpine produces "better hemodynamic stability than when either one is used alone."[1] In one series, more patients obtained adequate blood pressure reduction than from any single drug or combination of drugs previously reported.[1]

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Because of the potency of Methium, careful use is, nevertheless, required. Precautions are indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication.

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1. Ford, R. V., and Moyer, J. H.: Am. Heart J. *46*:754 (Nov.) 1953.

2. Crawley, C. J., *et al.*: New York State J. Med. *54*:2205 (Aug. 1) 1954.

Methium® with Reserpine

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pages of J.A.M.A.—the Journal of the American Medical Association—offering an $850-a-month job as assistant to a mining-company doctor. Rain called the Shay Medical Agency in Chicago and applied. On the basis of the unevaluated, freshly cribbed data Rain put in the application, the agency placed "Dr. Samuel P. Hall" in the office of the company doctor—who is now deceased—of the Inland Lime & Stone Co., of Manistique, Michigan. That was in September, 1946.

By April, 1947, Rain felt overextended and in need of travel. For one thing, he owed the Shay agency a fee of about $500, or 5 per cent of a year's salary. There was danger that the agency might become sufficiently irritated to investigate his claims. Besides, he had borrowed $1,000 on his signature at the bank, he owed for a new automobile, and he was deep in a love affair he wanted to break off. As a parting gesture, he walked out of a jewelry store with an unpaid-for expensive watch and took the week's receipts from the company doctor's cashbox.

Real Dr. Hall Alerted

It was at this point that the real Doctor Hall began to suspect that someone was impersonating him. Back from service and now getting established as a specialist in women's diseases, Doctor Hall, of Oakland, received a long-distance call from the Shay Agency. A woman's voice asked him for the $500 for placing him in Manistique, and she did not hesitate to tell him what she thought of him. "The tone was vituperative," recalls Doctor Hall.

He put the agency straight about himself, and then called Doctor Chandler, whom he knew well, the state board of medical examiners, the state narcotics division and the Federal Bureau of Narcotics. They all listened to him, but nobody was excited.

The phony "Dr. Sam Hall" was next heard from in a Fort Smith, Arkansas, hotel, where he described himself as a brain surgeon who had just lost his wife in an automobile accident. He had come down there for "a complete rest." After passing bad checks for $100 and more he left.

For three weeks he worked as an intern in the Coahoma County Health Department in Clarksdale, Mississippi. While in Mississippi he typed a letter on an American Cancer Society Field Army letterhead attesting that he was a capable physician "whose moral character is above reproach," and was not addicted to intoxicants or narcotics—which was true. To this letter, he boldly signed the name of Dr. Felix J. Underwood, state health officer, whom he had met once in Jackson.

Rain's public-health career was cut short by the Coahoma County sheriff, who noted his Michigan license plates and checked them against a circular notice asking the apprehension of "Dr. Samuel P.

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1. Vainder, M.: Indus. Med. & Surg., 22:183, 1953

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In a study of 180 patients, 91.8% experienced varying degrees of improvement, maintaining improved status without further medication.[1]

1. Magnuson, P. B. et al: J. Mich. State Med. Soc., 46:71

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Hall" for removing mortgaged property from Michigan. Two Manistique police officers came down to take Rain back, but meanwhile he had obtained an attorney, arranged for the repossession of the automobile and got out of jail, his doctor disguise unbroken.

Flies by Night

For a short time in June, 1947, Rain worked at the Jewish Sanatorium in Robertson, Missouri, near St. Louis. He left there in the middle of the night, mainly because he had landed a better job. The Camden-Clark Memorial Hospital in Parkersburg, West Virginia, a 154-bed city hospital, had advertised in J.A.M.A. for an all-around house doctor, or, as this duty is called, an "approved mixed residency." On the basis of a one-page application blank that Rain filled out and mailed in, plus a telephone call to see what the Jewish Sanatorium thought of him, the hospital hired him for $175 a month and his keep.

All this happened at a time when the administration of the Camden-Clark hospital was being reorganized. A new superintendent, Andrew M. Gould, now of Weirton, West Virginia, arrived. Displaying a praiseworthy if somewhat atypical itch to check up, Mr. Gould called "Doctor Hall" in and spoke to him about the lack of medical-school credentials on file for him.

The young man promised to take care of the matter, but had to be reminded again a week or so later. It was about this time that Rain told staff doctors he was not getting enough experience and would have to leave. Actually, he had been listed as surgical assistant for different doctors several times a week, but the chief of surgery had refused to use him, contending Rain was not ready for it—a fair appraisal.

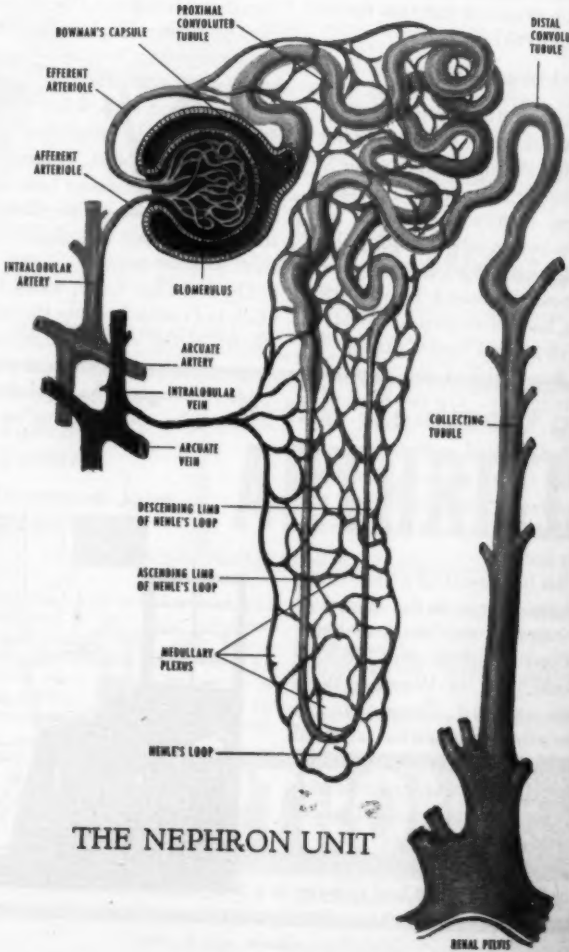
If Rain had stayed any longer at the hospital, he doubtless would have been exposed. Among those with some doubt about him was the staff pathologist, who thought it strange that Rain was unable to proceed with an autopsy.

On the other hand, when Doctor Hall, in Oakland, wrote the hospital the following year, he encountered evasive action. An Indiana pharmaceutical company had queried him, asking if he was the same Dr. Sam-



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ACTION AND EFFECTIVENESS

Mictine inhibits reabsorption of sodium ions by the renal tubule. In therapeutic dosage it has not caused any effect on glomerular filtration rate, renal plasma flow, cardiac output, heart rate or blood pressure.

Approximately 70 per cent of unselected patients respond to Mictine.

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Mictine is without serious toxic effects as used. It has not produced any alteration in the blood or blood-forming organs or in renal or hepatic function. At times headache or gastrointestinal symptoms (anorexia or nausea but rarely vomiting or diarrhea) have occurred, but, these effects may be reduced to a minimum by giving Mictine on an interrupted dosage schedule.

ADMINISTRATION

Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. In such patients, dosage is one to four tablets daily *with meals*, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days; or by its administration for three consecutive days and its omission for four consecutive days.

Mictine also may be used for *initial* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated. In these more severe congestive states, dosage is four to six tablets daily *with meals*, in divided doses on an interrupted schedule similar to those mentioned above.

SUPPLIED

Bottles of 100 uncoated tablets of 200 mg. each.

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uel Pike Hall it carried on its mailing list from Parkersburg. Gould said that a Doctor Hall had worked at the hospital for two months, but "we no longer seem to have any record of his forwarding address."

What had happened was no secret, and in part is recorded in Marriage Record Book 51, Page 298, in the county clerk's office in Parkersburg. In September, 1947, "Samuel Pike Hall" took one of the hospital's nurses, Margaret Joyce, as his wife. They thence departed for the Robinson Memorial Portage County Hospital in Ravenna, Ohio, where they both obtained jobs.

Again the situation was one of a new administrator with a dozen managerial headaches to solve, in keeping with the old saying among hospital superintendents that "if you haven't had at least one crisis today, wait a minute." The hospital had advertised in J.A.M.A. for a general resident doctor at $300 a month and maintenance, and Rain's application looked good.

Not thoroughly satisfied with the real Doctor Hall's record, Rain added some 1945-46 surgical training at Cook County Hospital. The hospital administrator checked on him by telephone with three doctors in Parkersburg whom he gave as references. All spoke well of him.

Rain's appointment in Ravenna expired in June, 1948. He left with

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Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

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a bona-fide letter signed by Dr. George G. Proskauer, of Akron, and addressed to Dr. J. C. Terrell, of the Stephenville, Texas, Hospital and Clinic. The letter stated that "Doctor Hall" was "co-operative and intelligent" and "will make good if offered the right opportunity." The phrasing was restrained to the point of almost complete accuracy.

For nine months Rain had been in charge of the Ravenna hospital's emergency room. During that time another house doctor, a Yale graduate, was fired for being nasty to patients.

By this time our picaresque hero had his pattern of imposture pretty well worked out. Everywhere he went he kept one eye on the near exit, collected professional testimonials, read the J.A.M.A. want ads and sent out job inquiries regularly. As he later explained, he felt it unwise to stay any place more than a year, a logical conclusion because most training appointments are made for periods of a year, beginning July first.

While he freely circulated a photograph of himself, he threw aside any answering letters demanding evidence of his qualifications, such as the certificate of credits routinely furnished by medical schools. This still left him with sufficient tempting offers.

The next one came from Stephen-

for early detection and better control of diabetes

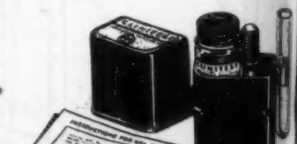
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REAGENT TABLETS

for detection of urine-sugar



*Barach, J. H.; Duncan, G. G.; Joslin, E. P., and Root, H. F.: Diabetes Mellitus, in Conn, H. F.: Current Therapy 1954, W. B. Saunders Company, Philadelphia, 1954, p. 368.

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Grace has two grown children who now live in other cities. After years of intense activity, she is left with little to do and think about. Her days are spent with the television set and telephone, and she is usually nibbling. Her weight increases slowly, but steadily.

You can help patients of this type with 'Dexedrine' *Spansule* capsules. One 'Dexedrine' *Spansule*, taken in the morning, controls appetite all day long, *between meals*, as well as at mealtime . . . helping to eliminate the succession of candies, snacks, and drinks that contribute so heavily to weight gain.

S.K.F.'s 'Spansule' capsules are the only sustained release oral preparations to be accepted by the A.M.A. Council on Pharmacy and Chemistry.

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ville, where the clinic needed an assistant surgeon. Rain's answer to the J.A.M.A. ad arrived while Doctor Terrell, the surgeon-in-chief, was in Chicago attending a medical meeting. Doctor Terrell's secretary, Mrs. Nichols, arranged by telephone to have him interview "Doctor Hall" at the Palmer House. Mrs. Hall came with her husband.

"Both people were rather personable, Doctor Hall being rather striking," says the surgeon, who was to distinguish himself from others on the Rain sucker list by taking action to expose and punish him.

Pay Is Good

Doctor Terrell employed Rain from July, 1948, to April, 1949. "I believe we started him at $900 a month, which is a very satisfactory salary for a man of his ability," he says wryly. Ironically, the J.A.M.A. published its first public warning about Rain six weeks after he arrived in Texas. Passing unnoticed, it said:

> Impostor—Anyone knowing the whereabouts of a person using the name of Samuel P. Hall and representing himself to be a physician should communicate with the prosecuting attorney at Manistique, Michigan. The person has been described as a white man, 30 years of age, 5 feet 11 inches tall, weighing about 160 pounds, with black hair, brown eyes and a small mustache, and as being a "classy dresser" . . .

This announcement was made by the A.M.A. Bureau of Investigation. In March, 1948, another department of the A.M.A. had issued a directory supplement reporting the movement from Oakland, California, to Parkersburg, West Virginia, of "Hall, Sml. P." It was this erroneous information which confused the mailing list of the pharmaceutical company and caused it to check with the real Doctor Hall.

He's Well Liked

In Stephenville, Rain established a nice home for his wife and their first child, a girl. "He seemed to be in the favor of everyone in town and was a lot more popular than I was," says Doctor Terrell, who has a sense of humor and the courage to admit that he was duped. In the next year the sense of humor was to be sorely tried.

Rain looked good as a surgical assistant at first, but, as was characteristic, he did not wear well. For one thing, he was unable to carry out certain procedures of examination and treatment, clearly revealing that he lacked the training in anatomy and physiology which he was supposed to have had.

Then, too, he could not keep his fingers out of the till. To his employer's mounting professional doubts were added the complaints of patients who received bills from the clinic upon which "Doctor Hall" already had collected the fees.

One day he was invited to resign and leave at once. He took with him

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$105 in checks he had persuaded health-insurance companies to make out to him.

For the next three months Rain found work in a similar hospital and clinic in Ballinger, Texas. Meanwhile Doctor Terrell, now fully aroused, looked into Rain's claims and turned his findings over to the county attorney. Like the real Doctor Hall, Doctor Terrell ran into a certain tendency on the part of hospital authorities to clam up. He wrote to the Portage County Hospital in Ravenna, for instance, but received no reply.

Confronted in Ballinger, Rain first said his real name was Dr. Frank Kay. That didn't check. He then explained that he was not from Stanford, but Northwestern University Medical School and had lost his license to practice in Illinois because he had done a criminal abortion. This was a lie too—at least about graduating from Northwestern and having had an Illinois license. It was less important to Rain to be called an abortionist and a crook than to be exposed as not being a doctor of medicine.

No Questions

What did his nurse wife think of all this? Well, she says, she knew he was in some kind of trouble, but he didn't say what, and she didn't ask.

On July 8, 1949, he was fined fifty dollars, plus $21.25 costs, for practicing medicine without a license—an offense considered a mere misdemeanor in Texas, as it is in most states. It was understood that he would sort of mosey on out of Texas.

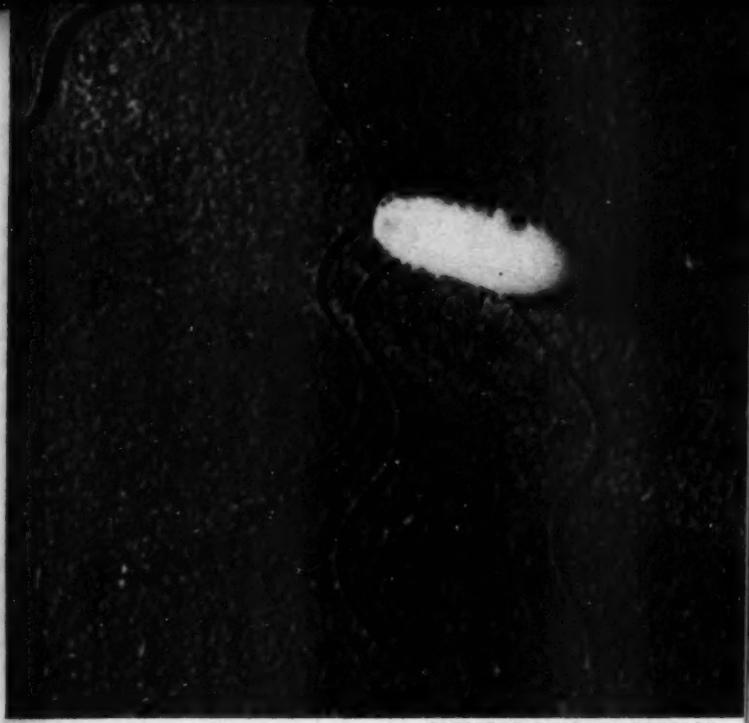
But Harold Rain liked Texas. He now entered upon the most stable period of his professional career. In San Antonio, he was able to hold two medical jobs more or less simultaneously, one for twenty-four and the other for thirty-four months.

Stays in Texas

While at Stephenville he had assisted Doctor Terrell in an emergency operation on J. R. Griffin, manager of the electrical department of the H. B. Zachry Construction Company, of San Antonio. Griffin had suffered a ruptured appendix and peritonitis while on a trip. Somehow, Rain led Griffin to believe that he had saved his life, giving Doctor Terrell no credit at all for three operations.

While Griffin more recently has acknowledged that Rain "isn't much of a man," he still—at last report—believed it was "Doctor Hall's" skill and knowledge of peritonitis that pulled him through. Such was this medical confidence man's ability to inspire faith in his patients and incidentally steal some glory. When Griffin's company flew him back home to convalesce, Rain attended him, met Griffin's associates and was told, if he ever was looking for a change, to come to San Antonio.

He was, naturally. The Zachry company hired him as medical and safety director, first part time and



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see page 90—91

MEAD

then full time, hiking his starting salary of $325 to $650 a month. This was a little less than Rain was accustomed to. When he saw an opportunity in June, 1950, for further patriotic service to his Government he volunteered. Fort Sam Houston, with a civilian-employee health program as well as military functions, was critically short of medical officers at the beginning of the Korean war. Rain signed a contract to work thirty hours a month at five dollars an hour as a "depot contract surgeon."

Red Tape Helps

Divided responsibility and buck passing were the main reasons no one checked up on Rain at this point. His papers were processed by one command and he was assigned to another. His main duties were to hold a morning sick call at the dispensary for ailing employees and to make the required physical examinations on job applicants. In one instance, he impressed Brooke Army Medical Center medical officers by sending them a case of heart disease turned up with his trusty stethoscope.

He held his two jobs, totaling $800 a month, until mid-1952. And then that old, rakish gleam in his eye threw him off balance. On a visit to a medical-supply house in search of office supplies, he met an attractive secretary. He began dating her.

In April, 1952, Mrs. Hall bore

him twin daughters. By May, the other-woman business compelled her to pack up the three children and return to West Virginia. Neither the lady who owned the furnished house in which "Doctor and Mrs. Hall" lived nor the neighbors could find much to say for him by 1953, when the probation officers came around to investigate his background. He didn't pay the rent, except under threat of suit, and he had frequent female visitors, they said.

Moves North Again

Topping it all, a state-board-of-medical-examiners investigator questioned him in his company office. Unable to produce a license to practice, Rain fell back on the one about really being Dr. Frank Kay, whose license was revoked in Illinois for committing an illegal abortion. The San Antonio episode was over, and he prepared to move on. At Fort Sam Houston, four medical officers dictated generous letters of recommendation for him.

This time—in July, 1952—he went to the little Olney, Illinois, Sanitarium and Clinic. Salary: $1,000 a month. To achieve this pinnacle, he was willing to promise much.

Now he was a specialist in obstetrics and gynecology, just as the new medical directory told him that the real Doctor Hall was. But Rain had made a romantic promise to return to San Antonio and, surprisingly enough, kept it. The records of the

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Bexar County clerk's office in San Antonio show that on September 8, 1952, Samuel P. Hall was married to Billye Lawson Bradley, a secretary. The records of the Bexar County courthouse, on the other hand, disclose that on September ninth, he was granted a divorce from Margaret Joyce Hall.

Whatever the legal technicalities may be, we thus can give Harold Rain credit for having been a bigamist for a day at least. His former wife was awarded $300 a month for support of their three children, a sum which he promptly and consistently failed to pay. His unpaid accounts in San Antonio department stores, mainly for men's and women's clothing purchased after May, were of interest, too:

Frank Brothers	$ 494.44
Frost Brothers	3,836.35
Hutchins Brothers ..	1,080.75
Pincus Company ...	171.70
Joske's of Texas	84.22
Total	$5,667.46

His Own Rx Blanks

The joy of fresh pretense filled Harold Rain's cup nearly to the brim in the next ten months. One of the first things he did in Olney was to get prescription blanks printed up. They said he was Samuel P. Hall, M.D., gave his address and telephone number, and informed pa-



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tients, "Practice limited to obstetrics and gynecology." In one corner of the blank was "Reg. No. 5193." This indicated that he was registered with the United States Treasury Department as having a tax stamp for the prescription of narcotic drugs, such as morphine and codeine.

He used his prescription blanks, which is equivalent to practicing medicine without a license, and, as any surgeon would, issued hospital orders for opiates and sedatives. Later he claimed he never had prescribed a narcotic drug. If he had not done so for his surgical patients, however, every nurse as well as doctor would have suspected him of irregular practice.

Treasury Department records for the Southern Illinois District show that he never was issued No. 5193. It was not issued at all in 1952, and in 1953 belonged to Dr. Frank S. Titchenal, of East St. Louis. The Treasury Department Bureau of Narcotics is mainly interested in dope peddling, and there is no evidence available that Rain ever was that enterprising.



Local Men Welcome Him

Though he pulled a boner or two, it was not difficult to see how the dozen or so doctors of Olney, a prairie town of 8,500, came to accept him and the new Mrs. Hall. In the first place, he was hired by Dr. Lawrence F. Weber, head of the clinic and president of the Richland County Medical Society.

During and after the war, the Olney Sanitarium, an eighty-bed hospital, for many years approved by the American College of Surgeons, lost ground. The war drew off many local physicians. Richland County became a little desperate for more doctors. The sick, admittedly, were not getting the attention they needed. In 1950 the hospital fell from the approved list.

The Olney general practitioners took Rain at face value as a much-needed specialist—a nice young fellow who got his training at a good school. He said that he was eligible to be examined and certified by the American Board of Obstetrics and Gynecology. How completely his arrival and departure reflected the state of flux in Olney was evident when, on July 1, 1953, shortly after he disappeared, the red-brick hos-

pital closed its doors, its place in the community taken by a new, larger county hospital.

There was a disturbing incident while "Doctor Hall" practiced in Olney. One of his patients was Mrs. Alberta Gross. Rain performed a hysterectomy on her, removing a large uterine tumor. In a week she went home, doing fine. Three or four days later she became ill and her husband summoned "the doctor." Rain told her there was nothing wrong with her, and departed.

Later the same night, her husband had to go out and find Rain, who, among other community activities, sang in a Methodist church choir. Mrs. Gross had taken a turn for the worse. Rain now brought another doctor with him, and this man immediately recognized a condition known as thrombophlebitis, in which blood clots form in the veins of the convalescent person's lower extremities. If they should break loose and plug the heart or lungs, they may cause death, as we have noted.

This frightening aftermath occurs willy-nilly in about one in 700 surgical patients, including those of the best surgeons in the world. The latter, however, have the advantage of recognizing what is happening and, if necessary, tying off certain veins to block movement of the clots. Rain wisely enough brought in a doctor who did the right thing and operated promptly.

Billye Hall was pregnant and having trouble with nausea and vomiting. "Sam," as she always knew her husband, drove her to the train in St. Louis for a trip home to Taylor, Texas, to visit her parents in early May. A week later he disappeared.

As she later recalled, "The only explanation I have for his sudden departure is that the pressure was bothering him a great deal. A short time previously I had asked him why there was no copy of his M.D. license at the clinic or at the house. I presume he thought someone had become suspicious at the clinic, but as I was to find out later, they were not, and were as shocked as anyone when the report from the A.M.A. came back saying Doctor Hall—the real Doctor Hall—resided and practiced in Oakland, California."

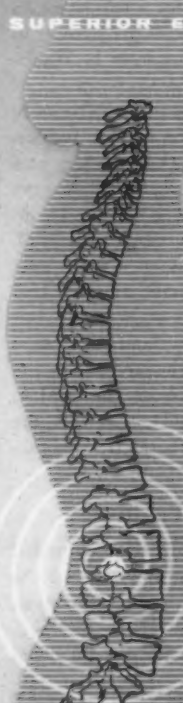
Stylish Fugitive

Once more, Rain felt compelled to flee from a fast-moving past. As always, he wished to depart in style. He bought a new air-conditioned, four-door sedan with $3,700 owed on it.

Borrowing $500 from the bank and converting it into traveler's checks, he drove away with nearly $2,000 in his pockets—including his last $1,000 pay, which came to only $790.46, after all those darned deductions.

This flight, in which he began to show signs of growing nervous in the service of humanity, took him to Wichita, Kansas, where, for six

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1. Bender, T. J. Jr.: at Mtg. Med. Assoc. St. Alabama, Mobile, 1954.
2. Jessup, R., Murray, R. J. and Rossi, A.: Amer. Pract. & Dig. of Treatment, 5:792, 1954.

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weeks in Wesley Hospital, he once more proved it is as easy to fool the big ones as the little ones. This 400-bed teaching hospital gave him a $250-a-month appointment as a resident doctor in obstetrics and gynecology. It was simple. He just walked into the hospital and told the pathologist in charge of the intern and resident training program that he was a doctor and was interested in getting Ob.-Gyn. training.

The hospital, short in staff, had a vacancy in that specialty. The pathologist sent him to the chief of obstetrics, and the latter reported to the pathologist, "We'd better snap him up before he gets away."

Rain filled out the usual one-page application and accepted a job beginning July first. Later the doctors mulled over how it had happened. One of them, it was recalled, had looked Samuel P. Hall up in the American Medical Directory and found background data generally in accord with what Rain said.

It was later noticed that the checker-upper had overlooked something additional in the real Doctor Hall's record. He didn't need any training in his specialty, for he was already certified by the American Board of Obstetrics and Gynecology.

Gets 'Fresh'

While Rain was generally regarded as a promising young doctor, he left some room for doubt at Wesley Hospital. For one thing, he was fresh with the nurses while on duty. "We thought he was pretty sharp, except that he was something of a roué," said one intern.

Then, too, he was inclined to berate anyone inferior to him for any mistake, no matter how trivial, often using insulting language. He argued with the senior doctors about their decisions and expressed opinions contrary to theirs. He committed a serious breach of professional etiquette by criticizing a doctor to his patient, and advised one patient to change doctors.

Wife Suspects Him

One person who suspected Rain of being a phony, from the first time she met him, was Mrs. Jerome S. Menaker, wife of a Wichita obstetrician. The doctor brought Rain home for dinner and Mrs. Menaker set out to make conversation with "Doctor Hall" in a vein like this:

Where are you from? . . . Illinois . . . Where in Illinois? . . . Just a small town . . . Oh, I'm from Illinois too—which town? . . . Olney . . . Where did you get your training? . . . You know, the usual places . . . But where? . . . Well, Stanford . . . Whom did you train under? . . . Oh, various guys . . . No one in particular? . . . No, just various ones.

At this point she became suspicious and, as she later told her husband, she thought it very strange to find a doctor who did not brag about his chief—the man who trained him. "Mark my word," she said

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at the time. "Someday you are go... to read about this man."

But soon Harold Rain depart... again. On August 5, 1953, he w... plained that his father was dying i... California—and headed east on ... new mission. What had flushed hi... was a second notice about himse... in the J.A.M.A. for August first. H... feared someone else at Wesl... might read the following:

IMPOSTOR SOUGHT

Information is urgently needed concerning the whereabouts of an alleged physician who uses the name of Dr. Samuel P. Hall . . . contact by wire Mr. Charles R. Vaughan, State's Attorney of Richland County, Olney, Ill. The man in question is described as follows: height, 5 feet 10½ in.; weight, 1[illegible] lb.; hair, black; age, 39; eyes, brown; complexion, dark . . . He is reported to have left his pregnant wife without support . . .

On the basis of information reach... ing the A.M.A. Bureau of Investiga... tion, it appeared that in five years Rain had gained nine years in age, lost one half inch in height, gained twenty pounds and had shaved off his mustache. His Wesley Hospital job was his twelfth since the Hines VA Hospital had given him his start in 1946.

It is conceivable that Harold Rain might still be practicing medicine someplace as "Dr. Sam Hall" if he had not decided to expose himself. A week after he left Wichita, Rain

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Dr. _____

Address _____

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presented himself at the offices of The Saturday Evening Post in Philadelphia and identified himself as Kenneth Hunter. He said that he wanted to sell the story of how he had successfully posed, to that moment, as a doctor of medicine.

"I have been living a big lie—for seven years," he said. "I know that I have to stop. However, I am afraid that if I just quit without exposing myself, I'll sometime be tempted to go back into medicine. I am an expert practitioner and surgeon, and I know I am very weak. I can always do well as a doctor, and if times got hard I would start to practice medicine again. Therefore, I want to expose myself so thoroughly that it will be impossible for me ever to practice medicine again. I am willing to start over as a laborer, but I would like to have some money to tide me over the lean period I will face."

A Rejection Slip

His story was fascinating, but, after thinking it over, the editors advised Rain they could not buy it. In fact, they said, they would have to notify the Wesley Hospital and national medical authorities. This was done.

Shocked to learn from the Post that "Doctor Hall" was a fake, Armour H. Evans, Wesley superintendent, called the FBI. Now, at last, a charge that would pursue Harold wherever he might go blinked at investigators like an electric

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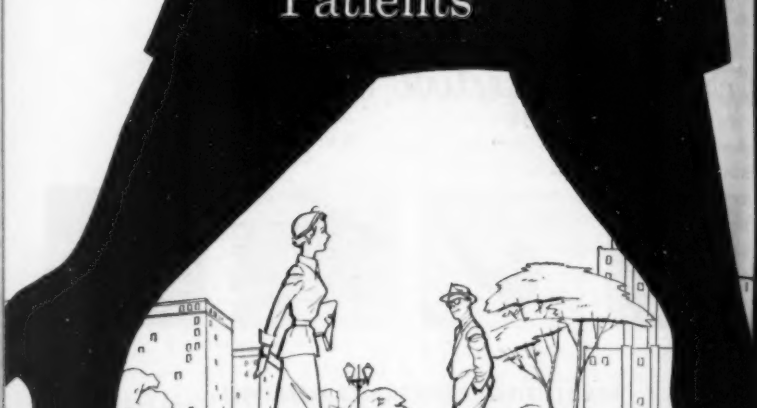
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sign. In Rain's last brief application, he had listed previous employment as an Army contract surgeon. If he had signed a contract, he had defrauded the Government by making a false statement that he was a physician—a far graver offense, as the laws stand, than practicing medicine without a license and merely defrauding patients.

Mrs. Billye Hall, who had the state's attorney in Illinois looking for her husband on a warrant charging wife abandonment, was able to tell the FBI where to look for the contract—at Fort Sam Houston. She also furnished photographs of him.

The Jig Is Up

With these to identify the impostor, two FBI agents were able to find Rain at the Flora Villa Hotel, 765 Cholson Avenue, Cincinnati. He was living quietly under his own name. His landlady was startled to see him pack in enough suits, shirts and other apparel "to start a haberdashery," she said.

The FBI had traced Rain through the traveler's checks he had purchased in Olney and later cashed as he traveled about in his air-conditioned automobile. Paradoxically, the bogus doctor had been careful not to become delinquent in his car payments and thereby provoke the finance company's wrath again.

Arrested September 9, 1953, Rain soon was giving interrogators an excellent exhibition of his firepower as a liar. The day after his arrest, he told Ewin B. Cunningham, United States probation officer, that Margaret Joyce Hall was his present spouse, denying any other. (She did not learn he was a phony until she received a letter from Billye Hall asking if she had seen Sam.) He falsely stated that his mother and father were dead, adding, "It was my mother's dying wish that I become a doctor."

"I wonder how I did it," he said, still abashed by his sudden arrest. In a few days, however, he recovered his poise and challenged the probation officer's competence. Not only Cunningham but FBI Agent Ralph D. House found Rain uncooperative in answering questions.

The FBI had no fingerprint record or record of prior arrest for Rain, and probation officers turned up no record of juvenile delinquency. Rain variously told court and prison officials that he was a member of the First Christian, Jewish Reformed or Jewish Orthodox faith and that his father was a Jew (untrue).

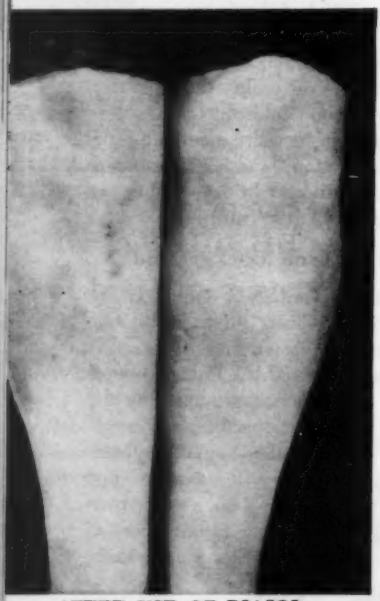
His True Background

From information gathered by probation officers in several states, and from my own investigations, it is possible to sketch in the general facts of Rain's background. I have a copy of his birth certificate. He was born in the little Kings Daughters Hospital in Perry, Iowa, on August 26, 1923, to John Rain, a thirty-two-year-old locomotive fireman born in Germany, and to Etta Parson Rain,

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thirty-one-year-old housewife.

John Rain is now a retired switching engineer living in Council Bluffs. He has a work record of forty-two years with the Milwaukee Railroad. He told me he and Etta had been divorced, remarried and separated again during the depression, when he was temporarily unemployed. She had taken Harold and his stepbrothers and stepsisters from a previous marriage to Long Beach, California. Harold was the only child by her marriage with John. Where was Etta now? John believed she was working in an Omaha restaurant.

A Lean Look

John is sixty-three. He said he had seen his son only twice since the boy was seven. Once was when Harold was eighteen and in the service. In his wallet, the father carries a snapshot of the youth at that age. It shows an enlisted man wearing an Army Air Force flight jacket, olive-drab pants and an overseas cap with an Air Force winged propeller insignia on it. He looked lean, in contrast to the photographs of five and ten years later, showing him well filled out and smiling happily.

Rain later professed to have forgotten his Army serial number. His military record has not been found under his own name, but the snapshot confirms his military service—unless he was impersonating a private, which seems unlikely. He denied that he ever was a medical corpsman, as many medical impostors have been. At one point he claimed to have been a military policeman.

His father wasn't fooled when Rain claimed to be a doctor, on the second occasion of their seeing each other. Harold was then a fugitive from Olney. "I was afraid to accuse him of lying, for fear of losing him again," said the father sadly. Asked why his son had turned out to be such a liar, the father said simply, "He growed up like a weed. He didn't have any bringing up."

Rain himself provided a brief flash of insight into his malnourished, gluttonous ego when he told the Post editors, "When I was a kid I was always poor. I had one pair of shoes. I had to wear those shoes on Sunday and every day. I hated doing this. Now I have twenty-five pairs of shoes and they're all expensive."

Now Rain is in the Federal Correctional Institution at Seagoville, Texas—a somewhat de luxe prison for more tractable offenders of Federal laws. Rain pleaded guilty when he appeared on October 30, 1953, before Federal Judge John H. Druffel in Cincinnati. Judge Druffel engaged Rain in an interesting colloquy which established to the court's satisfaction that, irrespective of Rain's own great, unfounded pride in his ability as a doctor, the man had been a public enemy:

THE COURT: How many serious surgical operations have you performed in your meanderings?

THE DEFENDANT: I have

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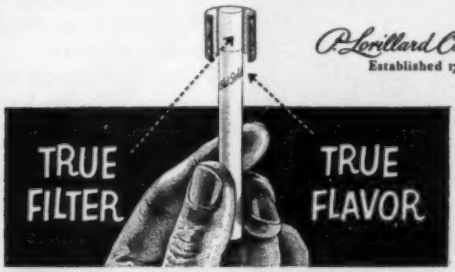
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For optimum results in dysmenorrhea



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exactly no idea, your honor.

THE COURT: Well, give us some idea.

THE DEFENDANT: Your honor, I was a resident for several years in various hospitals, and from seven-thirty in the morning until maybe twelve, two or three o'clock in the afternoon, I would be in surgical scrub . . . Sometimes we handled ten, fifteen, twenty or thirty cases a day.

THE COURT: Serious cases that you operated on yourself?

THE DEFENDANT: At that time I was assisting some of them. Some I was permitted to do myself . . .

THE COURT: What I am talking about are the cases you handled yourself.

Sentence Pronounced

About these Rain was silent, although Judge Druffel brought out the facts regarding Mrs. Gross' thrombophlebitis. Finally, he pronounced sentence:

"Your willingness to plead guilty saves you a much longer sentence. Of course, you realize that you have taken the lives of many of these people in your hands, who, through the neglect of the authorities of these various hospitals, permitted you to operate . . .

"Of course, everything you have done, as indicated by the district attorney's recitation of your activities, has been false and fraudulent. You are just a menace to the public; and, of course, fortunately for you, you



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are not up for manslaughter in some of these cases, which you could be under the circumstances . . . We will be lenient to this extent: Three years in the custody of the attorney general."

Some whom Rain duped thought the judge was too lenient. One was Col. W. A. Kostecki, post surgeon at Fort Sam Houston. In colorful, profane, but understandable language, the colonel contrasted his own four hard years in medical school and his four years in a Japanese prisoner-of-war camp with Rain's sentence.

"I was starved, beaten and tortured for four years," he sometimes tells visitors, "and that ——— is in a nice, comfortable Federal prison for three years, with time off for good behavior."

What of the real Doctor Hall, of Oakland? "It was a sad commentary on our society," he says. "Everybody took their licking and shut up."

That is not the whole explanation, however. The shortage of medical help, the fear of giving offense, a wish to avoid trouble, a low index of suspicion, and neglect to check statements, all figured in.

But the biggest asset of the confidence man is that his victims want to conceal their embarrassment. Thus they may pass him on, unexposed and unhalted, to the next one of the gullible. The signs of fraud were everywhere in Harold Rain's actions, but hardly anyone stopped to read them. END

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Jottings From A Doctor's Notebook

By Martin O. Gannett, M.D.

● From the armchair Hippocrates: The autopsy is the last act of the clinical drama. Before it, the clinician has played the stellar role, surrounded by a cast of secondary characters. After it, he may find that though all his gestures were perfect, he has been reading the wrong play.

• • •

Sixty-year-old Mose Brady, textbook model of alcoholic polyneuritis to a dozen generations of internes, has long been one of the fixtures in the neighborhood. The two characteristics that make him recognizable a block away are his tabetic gait and his glowing proboscis squashed flat many years ago in some barroom brawl.

As we reach his bed during rounds, Mose is engrossed in self-study in a pocket mirror. "Doctor," he says, ignoring our greeting, "I've been thinkin'. It's my nose that's to blame for everythin'. It gives me an inferiority complex and got me to drinkin'. Do somethin' for me, will-ya? Straighten my nose for me, and I promise you I'm goin' out of here a new man and start all over again."

• • •

For the third time in five years, Frank Hillier is in the hospital, recovering from a recurrence of his amnesia. Again, he can remember nothing of the ten-day hiatus in his recent past.

Like the figures of a pattern, certain intriguing features repeat themselves in all of Frank's amnesic episodes: Each time the attack comes on pay day. Each time, an obscure geographic instinct, no doubt akin

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to that of the spawning salmon, takes Frank a thousand miles away to Trenton, N.J.

An unexplained change from his usual penniless homecoming is the fact that the last time Frank took off, he left with $80 and came back with $355. The difference, wisely invested in a fur neckpiece for Mrs. Hillier, has done a good deal to liven her sympathy for her husband's affliction.

• • •

At the G-U conference Dr. Hunt reads the history of a patient with intermittent urinary obstruction, and shocks the audience to unwonted wakefulness with the startling information that ". . . at this time the patient began to have marked stammering."

Long John Finney opens his baby-blue eyes, shifts his weight to his cervical spine, and drawls thunderously: "Tell us at which end, Doctor."

• • •

Rheumatoid arthritis has bent and twisted Harry Gradle into a rigid distortion of the Discus Thrower. The one member not yet ankylosed is Harry's heart. The ward bulletin this morning has it that he is about to be married. Craning his neck painfully upward to meet my eyes, Harry confirms the news gaily.

"She's a widow woman, Doctor. I've had my eye on her for a long time. Perhaps you can fix it so we can be married in the recreation hall? Gettin' hitched comes under the head of recreation, ain't that so? . . . And, say, don't worry that I'm bent like a pretzel. I've got everything figured out."

• • •

Of my neighborhood colleagues who refer patients to the hospital, not all bear in mind the possibility that their hastily penned notes may be quoted. Two unfortunate examples reached the ward today, tacked onto the admission sheets:

"Please admit bearer to your free ward. I have been treating him for two years, and he must now be hospitalized . . ."

"Kindly admit Mr. F. Berson to your hospital. He has been under my care for the past three weeks. A thorough examination will reveal the diagnosis . . ." It did, too.

• • •

In one masterly stroke, the flamboyant Dr. Graham Link resolved a dangerous annoyance, while displaying to amphitheatre spectators a boyhood skill of high degree. For a full five minutes the adventurous fly had swooped, hovered, and dived about the operating table, the while a student nurse gestured after it with a halting and ineffective fly-swatter. Dr. Link straightened from his thyroidectomy, waved the nurse into outer darkness, then allowed the intruder to zoom within range. A whip-like dart of the arm, and between thumb and forefinger of the gloved hand fluttered the trapped fly.

To the applause of the audience,

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the doctor then executed his captive by immersion in the alcohol basin, called for a new glove, and proceeded about his business.

• • •

Dr. William Tartar, afflicted with previously undiscovered aortic stenosis, was admitting the epileptic Stanley Peterson to his neurological service when he himself staggered, fell unconscious to the floor, and twitched faintly once or twice.

The patient called for help; but in a moment Dr. Tartar had recovered from his transient cerebral anoxia and, with Stanley's help, climbed shakily to his chair.

The patient looked at his doctor a long moment, then turned to go.

"I guess I better not stay, Doctor. If I find someone to do me any good, I'll send you his name."

• • •

For Steve Keltos, a belated attempt at temperance turned out more of a physical than a moral strain. After thirty-two years of hard drinking and equally hard and uninterrupted work, Steve took the pledge and, to everyone's surprise, kept it.

Within two months, though, he had developed a crippling anginal effort-pain that stubbornly resisted all coronary vasodilators and reduced Steve to wheel-chair invalidism. It seemed almost as though the anginal syndrome had appeared as a withdrawal symptom.

As a last resort we prescribed a return, in moderation, to the whisky bottle. [MORE]

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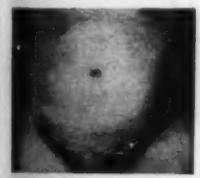


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1. Rigler, S. P. and Adams, W. E.: Experience with a new sprayable plastic as a dressing for operative wounds, Surg. 36:792 (Oct.) 1954. (University of Chicago Clinics, Chicago, Surgical Service).

2. Choy, D. S. J.: Clinical trials of a new plastic dressing for burns and surgical wounds, Arch. Surg. 68:33 (Jan.) 1954. (Bellevue Hospital, New York, Third Surgical Division—Dr. John Mulholland, chief).

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As a result, Steve is back at work again, and is free of pain. But, sad to report, he has reverted to self-medication, and has discarded all advice on dosage.

• • •

A man is never safe against his own enthusiasm. Ever since Miles Gillen began to dabble in immunology, there is hardly an ill to which flesh is heir that cannot be cured with a specific serum.

When he came out last week with a serum to control hiccough, I was strongly reminded of the famous Dr. R, who for many years was unable to investigate any disease without finding the streptococcus as its cause. Of him it was justly said that he was an excellent worker—exact, imaginative, painstaking. But that early in his career someone had painted streptococci on his eyeglasses.

• • •

At the conference on muscle disorders, the patient with myasthenia gravis sat listlessly on the platform as Dr. Vessen described the disease. The first discussant got up:

"Dr. Vessen has not touched on one interesting cause of remissions. I have seen two patients with myasthenia gravis as severe as that just presented, who became entirely well with each pregnancy."

On the platform, the drooping figure of the patient came to life. In a startling *basso profundo* he growled: "I'm game for anything, Doctor. How're you gonna do it?" END



© Medical Economics

"It's Mr. Whipple, the tax consultant. He says that if you'll cancel your bill for his operation, it'll put you in a lower tax bracket."

The House Of Menninger

[CONTINUED FROM 132]

average work week runs to fifty-five or sixty hours, with at least three evenings a week spent in seminars. "This place has the reputation in psychiatric circles of working its people *too* hard, if anything," the Menningers say.

All staff men are on straight salary, of course. The young staff psychiatrist starts between $7,200 and $9,000; and he can work up to $12,000 in five to seven years, if he has become a diplomate by then. The salary of a senior psychiatrist working full time at Menninger's runs around $15,000. A few "senior seniors" get close to $20,000. (The Menningers are on straight salary, too; they're paid only a few thousand dollars more than their most senior associates get.)

These are low ceilings, by private practice standards. According to the Seventh MEDICAL ECONOMICS Survey, *median* incomes in the specialty in 1951 were $18,000 gross and $13,000 net. Apparently, though, the Menninger staff finds other satisfactions, beyond the financial, in working there.

The professional staff naturally finds much of this other satisfaction in the training program. Topeka is the only place in the world where you can find 100 psychiatric residents encompassed in one organization. Residents are known as Menninger Fellows; and they're selected by a rigorous system of personality tests and personal interviews. About half of all applicants are called to Topeka for the two-day ordeal, and about three-fourths of these are chosen to remain for three years.

How It Began

The king-size training program grew from a cooperative venture of the Menninger Foundation and the Veterans Administration. In 1945, the V. A. desperately needed more psychiatrists; so it took over the Army's Winter General Hospital in Topeka and made it available to the foundation for training purposes. Result: the Menninger School of Psychiatry, which soon became the world's most fertile seedbed of its kind.

The richness of affiliated activities is mainly what attracts candidates for psychiatric training. A Menninger Fellow may work, for example, in the Southard School, a dynamic center for child psychiatry, and also at the Kansas Boy's Industrial School for young delinquents. He has a tour of duty in a community guidance clinic and another at a colony for mental defectives.

Thus he gets a taste of nearly every subspecialty in the field of psychiatry. By the time he completes his training, he has learned to work smoothly with all related disciplines. [MORE▶

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Only a minority of the alumni—125 out of 400 so far—have entered the more lucrative field of private practice. It's interesting to speculate why this is so—why a specialist who *could* earn as much as $35,000 on his own prefers to accept an appointment at as little as $9,000.

The answer probably reflects another aspect of his training—i.e., exposure to the Menninger brothers. It's obvious that either of the Menningers could increase his income tremendously by going into solo practice. Their devotion to the group ideal puts stars in the eyes of many a trainee.

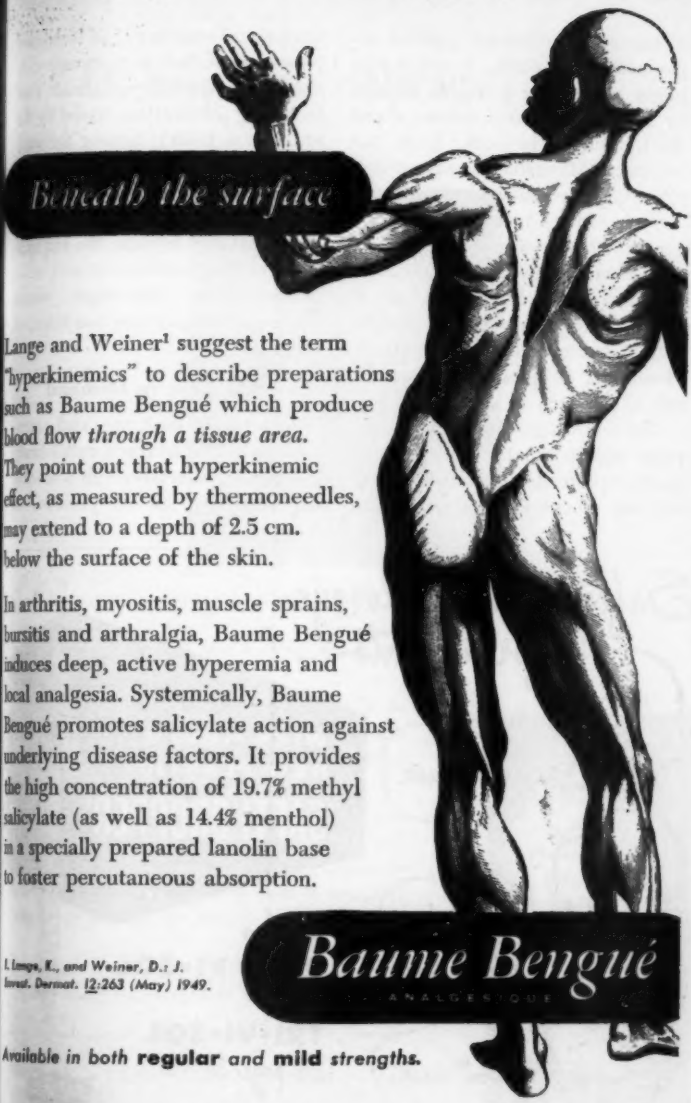
Home-Town Reception

Unlike some prophets, the Menningers are definitely honored in their home town. And Topeka is no prouder of the famous brothers than the Menningers—both native sons—are of Topeka.

Among the local private doctors, cordiality toward the Menningers is a bit less unanimous. Some of them are suspicious both of group practice and of foundations. Some believe that it's harder for a G.P. to win full local acceptance when he functions under the shadow of a renowned clinic.

Yet, once the Topeka doctor gets out of eastern Kansas, his attitude is likely to change. You'll find him speaking with pride of the Menningers, because of whom his small city looms large on the medical map.

The Menninger Foundation is one



Lange and Weiner[1] suggest the term "hyperkinemics" to describe preparations such as Baume Bengué which produce blood flow *through a tissue area.* They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin.

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1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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of the most-publicized medical organizations on earth. A visitor can prime himself for a trip to Topeka by reading dramatic articles about the foundation in Look, Time, the American Magazine, or almost any other big-circulation medium.

Such articles bring the Menningers much criticism from medical sources and many pleas from impecunious readers. But foundation officials claim that not one private patient has ever entered the C. F. Menninger Hospital as a direct result of publicity in a lay magazine.

The really important publicity appears not in the lay press, but in quieter professional journals. During one recent year, twenty Menninger staff members had forty-nine papers published in forty-one different professional periodicals (not including publications issued by the foundation itself). Among the variety of subjects they wrote about: the rhythmic activities of school children; social tensions in India; the making of friends; the implications of the barber-customer relationship. The Menningers wrote seventeen, or just over one-third, of these papers.

Speakers in Demand

In a recent year, too, staff members gave 200 lectures, radio interviews, television talks, and after-dinner speeches, all on professional



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topics. This was apart from the lectures and routine activities incidental to their regular duties. Between them, the Menninger brothers delivered thirty-six talks—just over one-sixth of the total number.

In addition to all these activities, the foundation sponsors four periodicals:

The Menninger Clinic Monograph Series consists of research treatises issued through commercial publishers. The Menninger Quarterly circulates among foundation members. Then there's the newsy Bulletin of the Menninger Alumni Association. And, finally, there's a top-level journal of psychiatry, the Bulletin of the Menninger Clinic.

Why Some Object

Just what does American medicine think of this psychiatric colossus? Naturally, there's some hostile criticism. One small anvil chorus of men still half believes that "F-r-e-u-d" ought to be spelled "f-r-a-u-d." Since they distrust all analysts, they're bound to deplore the big psychoanalytic machine that functions so smoothly on the banks of the Kansas River.

Then there are some who contend that it's not good for a single agency to train 10 per cent of the country's residents in a specialty. Since Menninger alumni scatter to all parts of the U.S., these critics doubtless include a few anti-Menninger psychiatrists who have the uncomfortable feeling that Topeka-trained

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men are always looking over their shoulders.

This attitude may help account for the bitterness of a still smaller—but highly vocal—body of physicians who claim that the Menningers dominate or are trying to dominate American psychiatry. (Dr. Will was president of the American Psychiatric Association for a year; but Dr. Karl has never held elective office in that body. So the basis of the charge is probably just the number of Menninger-trained men in the field.)

Too Much Publicity?

The steadiest fire comes from those who complain that the Menninger Foundation and the Menningers themselves take up far too much space in the popular press. Such critics will hasten to quote you the canons of medical ethics that frown on personal publicity.

Friends of the Menningers—and they're legion—have direct answers to all the major complaints.

They point out, for example, that the Menninger Foundation attracts its residents in open competition with other noted training centers. No special inducements, such as higher stipends, are offered. On the contrary, the foundation is one of the very few such centers to charge a tuition fee.

Any influence Menninger alumni exert on American psychiatry, they assert further, comes from successful application and development of the techniques they've learned. It can't possibly come, they insist, from political machinations.

As for the unavoidable attentions of the lay press, say the defenders, it wasn't dramatic publicity that made the Menninger Foundation famous; it was the foundation's fame that made it newsworthy.

Since the Menningers aren't engaged in the usual sort of private practice, they get no personal benefit from the write-ups. In fact, "Menninger" as applied to the foundation actually refers to their father, and reflects on the sons only as mention of the Rockefeller Foundation, say, reflects on John D. Rockefeller Jr.

Psychiatry Approves

On the whole, the main body of American psychiatry takes a sane and cheerful view of the Menninger phenomenon. This view has been pretty well expressed by one non-analyst:

"You don't have to be completely enchanted by the Menningers to realize that they *are* important. They have made a permanent mark on psychiatry. And like all people who stand out, they make easy targets.

"I know of no one else who has had the vision to correlate psychiatry with so many aspects of life, the boldness to make such rich use of ancillary specialists, and the ingenuity to develop so effective a training program. Where psychiatry is concerned, the Menningers have fired the imagination of the world." END

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News

What the hospital owes its doctors • Are M.D.s becoming too 'narrow'? • Cites need for an additional 55,000 nurses a year • 25 per cent limit on income taxes sought • Expert sees no chance of another crash

Urges Abolition of Specialty Boards

Adding fuel to the recurrent flare-ups over certification, the Norfolk Medical News has come out in favor of abolishing the specialty boards. Authority for certification, says the Massachusetts journal, should rest "directly in the hands of the A.M.A., *not* in the hands of self-appointed groups which are autonomous and prone to act autocratically."

Spurred by a report of the Committee on Graduate Surgical Education (which also advocated dissolving the boards), the journal points out that the requirements of certain specialty boards are so inflexible that they can't be met even by "some men of unusual talent."

Result: "a class distinction among physicians . . . Those who are looked upon as pariahs seek to join some other organization more flexible in regard to certification. If the outcast physicians feel there is no organization comparable to the one from which they have been excluded, they attempt to set up one of their own. Thus there are Boards and more Boards—and Boards within Boards!"

There's no escaping "this type of bureaucracy," except through a central authority, the Norfolk journal concludes. And any such authority "must be vested in the medical profession as a whole; *i.e.*, the A.M.A.!"

Cold-Shoulder Kaiser Plan in Hawaii

If Henry J. Kaiser takes his Kaiser Foundation Health Plan to Hawaii, he won't find local doctors at the wharf bearing leis to welcome him.

The California tycoon recently tried to lease beds in two Hawaiian hospitals as a step toward linking the islands to his West Coast health plan. Hawaii's physicians pointedly countered by officially reaffirming their faith in the existing prepayment plan, sponsored by the Hawaiian Medical Association.

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2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
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4. Turell, R.: New York St. J. M. 50:2282, 1950.

ficial opposition to the Kaiser system. But they clearly implied they saw no need for it. Editorialized their medical journal: "The doctors in this community would like to go on solving their own medical care problems in their own way."

What Should You Expect From Your Hospital?

Doctor ticks off obligations due to all staff M.D.s

When you recommend a hospital to a patient, you're giving it your stamp of approval. You're also committing your professional reputation. In return, you have a right to expect certain things of that hospital, says Dr. Charles U. Letourneau, secretary of the American Hospital Association's Council on Professional Practice. His list, as compiled for Trustee magazine:

1. Clean, safe, quiet accommodations for your patient.

2. Efficient equipment, "modern in design and in good working order," as well as high-quality supplies of all kinds. In particular, says Dr. Letourneau, no substitutions in drugs "are permissible."

3. Nutrition adequate to your patient's general or special needs.

4. Facilities for standard laboratory tests, performed by "alert and competent" technicians.

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DR. CHARLES U. LETOURNEAU

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9. An adequate system of professional control, to assure you of qualified colleagues.

10. An absolutely obedient and loyal hospital staff. "Wisecracks, innuendoes or outright slanderous statements about any doctor on the . . . staff must not be tolerated."

11. Security of the confidential

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relationship between physician and patient.

12. Facilities for research and study.

13. Protection against discrimination "on the grounds of race, creed or color," as well as reasonable assurance that your staff privileges won't be revoked without just cause.

Cleric Warns M.D.s Not To Be Too 'Narrow'

Is there a similarity between the anti-clericalism of past history and the growing anti-medicalism of today? Could be. Doctors have attained such a privileged status that they're bound to be targets of criticism, says Catholic priest Raymond T. Bosler.

In a guest editorial in the Indianapolis Medical Society Bulletin, he points out that the public has a way of first spoiling, then renouncing, those whom it too blindly reveres. "Take it," he adds, "from a member of the clergy who knows a little something about anti-clericalism."

He carries the analogy even further: Europe's ancient quarrel with the church, he says, was brought on largely through the narrowness of the clergy—a narrowness due to "an extremely narrow education." And the modern doctor is in danger of falling into the same trap.

"There is an alarming narrowness



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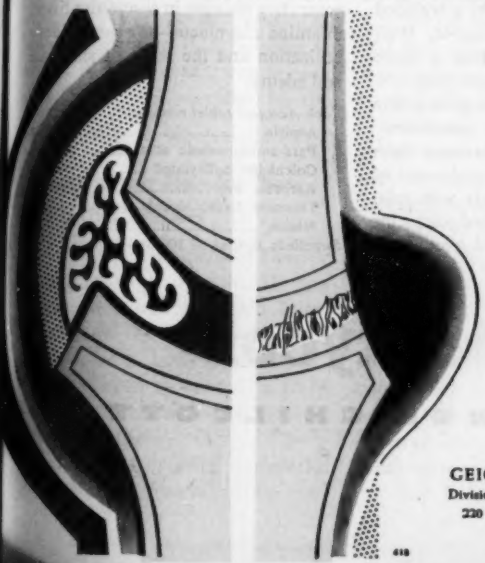
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evident in doctors today, particularly the younger ones," he says, adding that "many doctors know nothing but medicine, talk nothing but medicine."

In the end, he warns, this kind of overspecialization can lead to trouble: "Narrowness will cut you off from others, blind you to your own faults, and lead ultimately to [serious] anti-medicalism."

Still Too Few Nurses

It seems as though there can never be enough nurses. U.S. Surgeon General Leonard A. Scheele estimates there are 389,600 professional nurses in the country—an increase of 16,000 since 1950—but he warns that their number isn't growing fast enough. The immediate need for nursing services is so great, Dr. Scheele points out, that, in order to meet it, at least 55,000 young people will have to be recruited for the profession in 1955.

Chiropractor Hawks New 'Vitamin Product'

Leo L. Spears, enterprising Denver chiropractor, is at it again. He has now begun to sell a bottled "vitamin product" by mail. It is not a medicine; it's a "body conditioner." And it's alleged to contain a truly spine-tingling collection of ingredients. Among them:

Sassafras, sarsaparilla, camomile, poke root, manganese citrate, cobalt gluconate, sulphur, potassium chloride, and prickly ash.

The elixir is named "Booster," and all profits from it are to go to the Denver chiropractic hospital that bears Spears' name.

Would Set Income Tax Ceiling at 25%

Not satisfied with the big tax revisions of 1954, Representative Chauncey W. Reed and Senator Everett Dirksen—both Republicans of Illinois—are promoting an even bigger revision in the form of a Constitutional amendment.

If the two legislators have their way—and their chances at the moment seem slim—Congress would (1) establish a ceiling of 25 per cent on all personal income taxes; and (2) relieve itself of the right to levy gift and inheritance taxes (and return such means of raising revenue to the individual states).

That's not all. The Reed-Dirksen scheme also stipulates that Congress may not raise income taxes *above* a 25 per cent ceiling except in time of emergency—and then only by a 3-to-1 vote of its membership. And the plan provides further that if the ceiling *is* raised, it must never exceed the bottom rate by more than 15 per cent. (The present gap is 71 per cent. That is, high incomes today can be taxed as much as 91 per cent, while no one—above a certain minimum—gets away with less than 20 per cent.)

[MORE▶

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Before you go out and buy a yacht or two on the strength of the money the proposal would save you, remember this: Even in the event that the amendment should somehow get by Congress, it would then have to be approved by a two-thirds majority of the states.

What Are the Chances Of Another Crash?

Economist says the odds are 250 to 1—against it

In these days of a generally rising stock market, you've doubtless heard warnings from those who fear that the country's financial structure may come crashing down as it did in 1929. Is any such debacle in the making? William Blocth, top financial writer for the New York World-Telegram and Sun, doesn't think so.

"Under extreme conditions," a crash might come, he wrote in a recent column. "But it would require another speculative binge like that of the Twenties. On top of this, there would have to be a concerted urge to sell that only a major catastrophe might induce. In short, the odds against it are about 250-to-1."

Blocth goes on to note another good reason why a recurrence of the 1929 tragedy is unlikely: Most of the abuses that helped bring it about have long since been done away

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with. He cites the following safeguards, enacted during the past twenty-five years, as insurance against catastrophe:

¶ Marginal buying has been sharply curtailed. To make sure that investors won't overextend themselves, the Federal Reserve Board now has the power to set the legal minimum margin—and to change it "as the situation warrants." Currently, for instance, the investor must pay for at least half of each purchase in cash—a conservative margin indeed by 1929 standards.

¶ "The Securities and Exchange Commission, set up 20 years ago, has promulgated hundreds of regulations to prevent another 1929 crash." One of the most important: "Company officials and large shareholders must report their transactions periodically." Another: The S.E.C. has "outlawed the infamous 'pools.' No longer can a group of insiders generate high activity and inflate prices artificially as a lure for unsuspecting investors."

¶ "Steps have been taken to keep stock market fluctuations from affecting other branches of the economy." Banks, for example, are now forbidden to "underwrite corporate securities." This regulation, says Bloeth, has severed "a major link between market upsets and the solvency of the banks"; and it's largely responsible for the fact that "there

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hasn't been a major bank failure in a decade."

¶ The floating of new securities issues is more strictly controlled than it was in the Twenties. Today, Bloeth points out, "the law requires that all pertinent facts must be disclosed." Thus, if a stock is highly speculative, the investor is forewarned.

The financial expert concedes that despite these safeguards, "there is still no way to prevent the majority of holders in any particular stock from selling simultaneously." And he admits that such "unanimity"—particularly if it occurred among the vast investment companies—could well "raise havoc" with the whole market. But he maintains that there's nothing in the wind that would indicate any such selling trend in the near future.

Treat Me, Doctor, With A Boogie Beat!

The patient was sure he had seen the young physician before; but for the life of him he couldn't remember where. Then it came to him. "Say, didn't you play in Gene Krupa's band a few years ago?" he asked.

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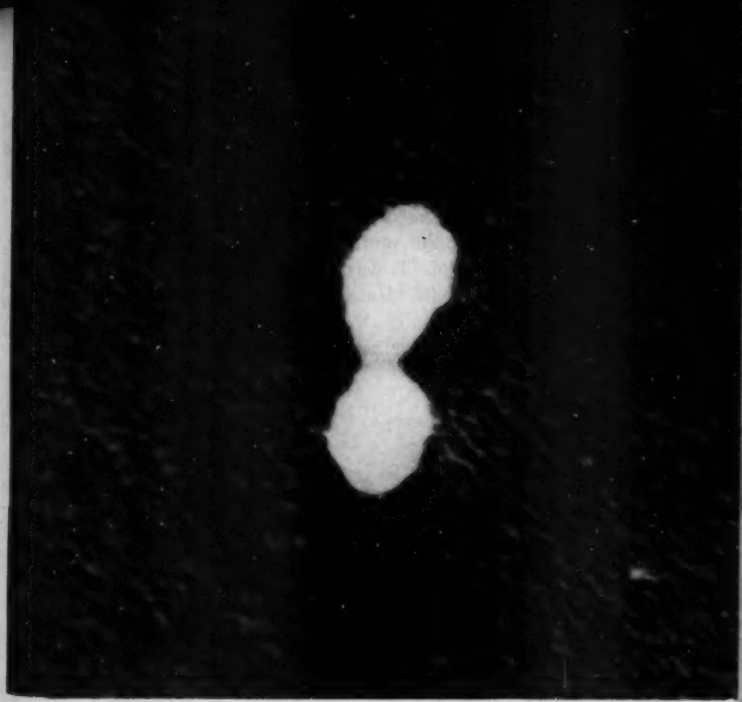
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from saxophone to stethoscope dates back about a decade. A top "side man" with several name bands, he had been barnstorming around the country for some four years when he decided the musician's life was not for him. "It was fun," he says now. "But the future was kind of shaky."

So he resurrected an earlier ambition and went off to medical school. He graduated in 1952; and today—34, and the father of three children—he's building up a practice in Des Moines, Iowa.

Has Dr. Olson given up playing altogether? By no means. "When I have time," he says, "I still like to pick up the old sax and give out with a few hot licks."



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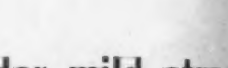
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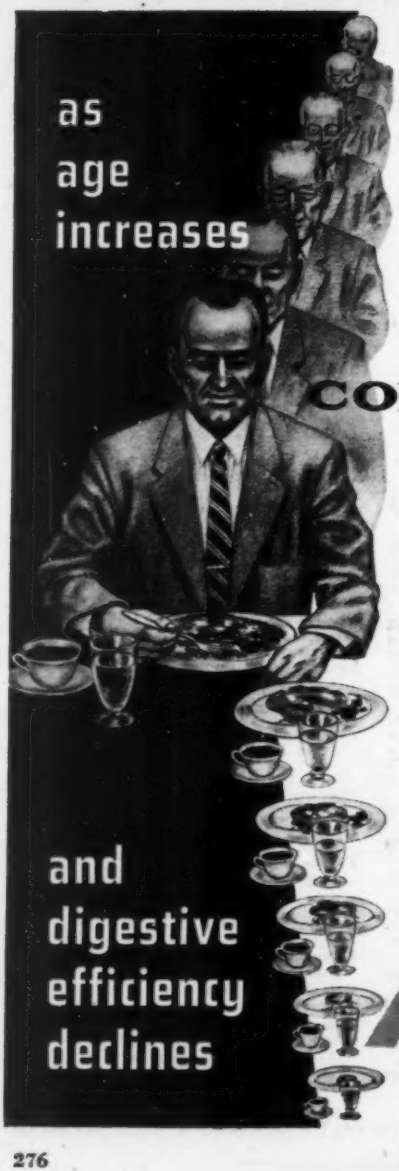
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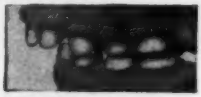
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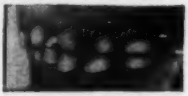
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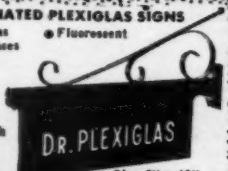


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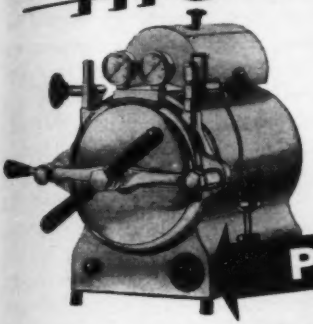
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Memo

FROM THE PUBLISHER

What You're Spared

In the mail the other day came a manuscript entitled "Medicine, a Chance to $erve." It was an hysterical, unauthenticated diatribe that labeled physicians—all physicians—as money-hungry incompetents.

We read every word, then returned the manuscript to its author, a Los Angeles social worker.

All kinds of people (including cranks) send in all kinds of material (including invective) that they'd like to have you read. But 95 per cent of their offerings, we find, aren't really worth passing along to you.

Why so many rejections? Well, it *isn't* because we demand perfect grammar and syntax. It isn't because we demand ideas flattering to doctors. Here are the three main types of material we reject:

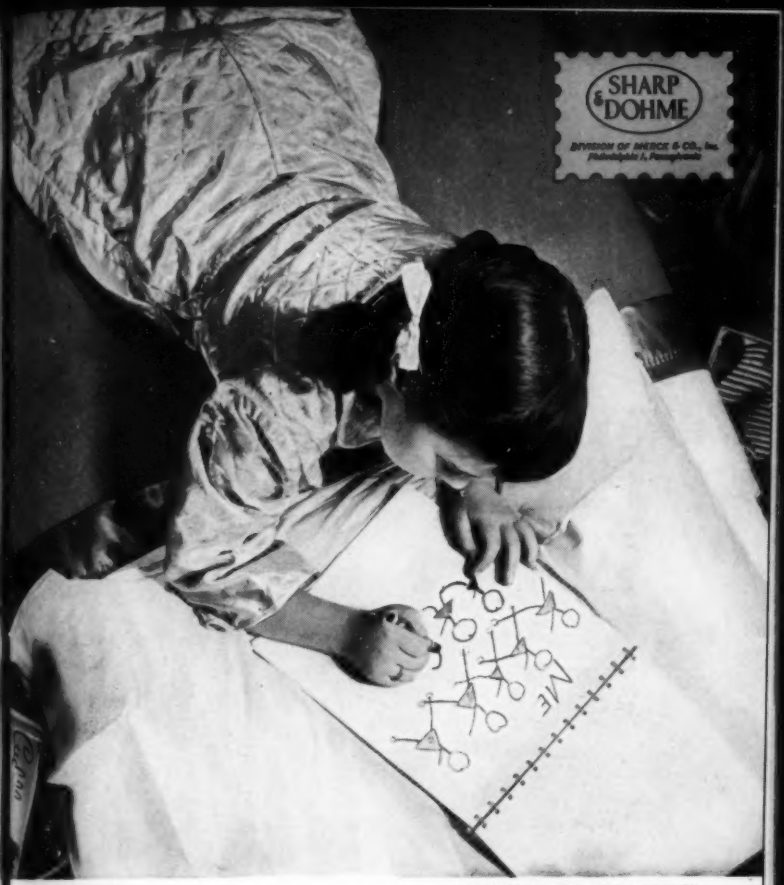
1. *The clinical paper.* Since MEDICAL ECONOMICS is devoted to the business and personal side of medicine, purely clinical contributions are out of place. And still we get manuscripts like "Heterosexual Hormones" and "Bronchial Asthma." Rather than move into this field—which hundreds of medical journals already cover—we prefer to stick to our own exclusive beat.

2. *The theoretical article.* As a rule, our articles emphasize how things actually *are* done, rather than how they theoretically *should* be done. Philosophical excursions are occasionally interesting; but most that we receive aren't helpful enough to warrant space. (Recent example: "Socialized Medicine—a Theory Concerning Its Pathogenesis.")

3. *The catch-all manuscript.* No one article can deal adequately with all aspects of a complex subject. With too much ground to cover, the author can't dig deep enough anywhere along the way. We frequently have to turn down such overly inclusive compositions as "The Doctor and His Taxes" and "This Whole Matter of Fees."

There you have three types of manuscript that we generally shunt aside. There are plenty of other types, too, on which you probably wouldn't want to waste your reading time. In one recent afternoon, we received and rejected "Specialties Are in Style" (too obvious); "Advancement of Medicine in Corpus Christi, Tex." (too local); and "Organization of a Teaching Department of Urology in a County Hospital" (too limited).

Only one manuscript out of every twenty offers the values we think you have come to expect of MEDICAL ECONOMICS. Yet the ratio is far more favorable for contributors who remember our long-standing aims: to help, to inform, to stimulate, to entertain. —LANSING CHAPMAN



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